

Provider Related Policy and Procedures

P&P	Title, Date of Approval, File Reference Number
80.212	Quest Encounter Data Collection Process, 3/11/2004 (A6469)
80.308	Initial Credentialing of Licensed Health Care Professionals, 7/14/2003 (A6799)
80.308.1	Re-Credentialing of Licensed Health Care Professionals, 7/15/2003 (A6800)
80.308.2	Initial Background Verification and ReVerification of Unlicensed MH Pro and Para, 7/15/2003 (A6809)
80.308.3	Delegation of Credentialing Primary Source, 7/15/2003 (A6798)
80.402	Confidential Fax Transmissions, 4/3/2003 (A6485)
80.405	Mandatory Reporting of Child Abuse or Neglect, 2/5/2003 (A6217)
80.601	Consumer Handbook, 7/21/2003 (A6218)
80.602	Seclusion and Restraint, 7/9/2003 (A6762)
80.603	Grievances and Grievance Appeals, 7/15/2003 (A6420)
80.604	Denial of Services and Appeal – 7/14/2003 (6781)
80.705	Assessing Services from CAMHD Contract Providers, 3/19/2003 (A6226)
80.805	Sentinel Events / Incidents, 3/31/2003 (A6432)
80.813	Notice of Privacy Practice, 3/28/2003 (A6408)

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Quest Encounter Data Collection Process	Number:	80.212
	Page:	1 of 2
REFERENCE: Hawaii Prepaid Medical Management Information System Health Plan Manual; Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, parts 160-164	APPROVED:	
	<i>Signature on File</i> Chief	11 Mar 04 Eff. Date

PURPOSE

To establish operational guidelines within the Child and Adolescent Mental Health Division (CAMHD) for the Quest encounter data collection process.

DEFINITIONS

“Encounter” - a record of a contracted treatment service rendered by a CAMHD contracted provider to a registered CAMHD client.

“Adjudicated encounter data” – Encounter data that has been fully verified by CAMHD Management Information System (MIS) Section to be complete and accurate.

POLICY

1. The CAMHD shall ensure that all CAMHD contracted treatment services providers submit encounter data for covered services provided using an electronic database that tracks clients, service authorizations and billing information that adheres to the CAMHD’s methodology in determining client outcome measures and HIPAA mandated requirements & guidelines.
2. The CAMHD-MIS Section shall maintain and submit adjudicated encounter data to the Med-Quest Division (MQD) electronically on a monthly basis conforming to the data element specifications defined in the Hawaii Prepaid Medical Management Information System (HPMMIS) Health Plan Manual and in accordance with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PROCEDURE

1. CAMHD contracted treatment services providers will:
 - A. Post an accurate monthly electronic billing submission in the 837X12 HIPAA compliant format to the secure CAMHD HTS server website for authorized services within 90 days of the month that the services were rendered. Billings must be posted to the CAMHD HTS server website no later than 3:00 p.m. of the 90th day.
 - B. Fax a signed certification of accuracy, completeness and truthfulness of the data by the provider’s CEO, CFO or Local Program Director to CAMHD MIS Section by 3:00 p.m. on the day the billing is submitted.

REVISION HISTORY:

Initial Effective Date: May 7 2003
Biannual Review Date:

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A6469

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Quest Encounter Data Collection Process	Number:	80.212
	Page:	2 of 2

- C. Contact CAMHD-MIS Section for assistance regarding the X12 transaction files and the transmissions.
 - D. Contact the Family Guidance Center (FGC) for assistance related to changes to Service Authorizations and/or Client Registrations.
2. The CAMHD MIS Section will:
- A. Maintain a roster of clients registered as eligible with QUEST & CAMHD.
 - B. Utilize adjudicated billing information for CAMHD's QUEST eligible clients from CAMHD providers. The information is to be fully disclosed to MQD with no material omissions.
 - C. Submit only complete, fully edited, and verified encounters to MQD with a signed certification attesting to completeness, accuracy and truthfulness of the data. Encounter data is not complete if the data has missing or incomplete field information.
 - D. Manual Billings from providers are processed and fully validated by CAMHD Fiscal section who will attest to the accuracy of the data.
 - E. Manual data will be passed to the CAMHD MIS section in the appropriate format with all fields required by MQD, HIPAA and CAMHD business rules according to the agreed upon submission schedule.
 - F. CAMHD MIS will add the fully adjudicated data from fiscal to the encounter submission to MQD.
 - G. Submit 80% of encounter data to MQD no later than 120 days from the end of the month in which the services were rendered; 100% within 15 months of the end of the month in which the services were rendered. Adjustments, re-submittals and Third party Liability (TPL)-related encounters are not subject to the 120-day submission requirements.
 - H. Review, correct and resubmit pending encounters that do not meet the requirements of the MQD full edit/audit process.
 - I. Electronically transmit all submissions via a secure file transfer protocol (FTP) network process to MQD.
 - J. Keep on file in CAMHD MIS Section detailed screenshots of the MQD encounter process.
 - K. Keep on file in the CAMHD MIS Section an updated HPMMIS Health Plan Manual to be used as a reference for guidelines on information exchange between the CAMHD-MIS Section and MQD.
 - L. Ensure that all encounter data is handled only by authorized personnel of the CAMHD-MIS Section.

ATTACHMENT: None

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	1 of 21
REFERENCE: HRS; HI QUEST; QARI; HI State; Licensing Boards; CMSS; CAMHD QAIP; NCQA Standards for Credentialing & Recredentialing: 42CFR; §438.12, § 438.200, § 438.204, § 438.206, § 438.214, §438.224; HSAG Audit Tool; HAR, Title 11, Department of Health, Chapter 98, Special Treatment Facilities	APPROVED:	
	<i>Signature on File</i> Chief	14 Jul 03 Eff. Date

PURPOSE

To assure competent, safe, and effective practices by licensed qualified mental health professionals serving Child and Adolescent Mental Health Division (CAMHD's) consumers.

DEFINITIONS

See Glossary of Credentialing Terms (Attachment 1)

POLICY

I. Credentialing Policies

A. Practitioner Credentialing Guidelines

1. Any State of Hawaii licensed practitioners who either have an independent contract with CAMHD, employed with CAMHD, or is employed or subcontracted by CAMHD Contracted Provider Agencies is covered under this policy.
2. Credentialing of the following State of Hawaii Licensed practitioners are covered under this policy: Medical Doctor (M.D.), Licensed Social Worker (LSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist (Ph.D. or Psy.D.); Advanced Practice Registered Nurse (APRN), and Osteopathic Doctor (D.O.)
3. *Licensed Practitioners who do not need to be credentialed by CAMHD:*
 - a. Practitioners who practice exclusively within the inpatient setting and who provide care for CAMHD consumers only as a result of the consumers being directed to the hospital or another inpatient setting. These practitioners need to be credentialed by the hospital or the inpatient setting they provide services.
 - b. Practitioners who do not provide care for CAMHD consumers in a treatment setting (consultants).

B. Criteria and Primary Source Verification used to verify licensure:

1. State of Hawaii licensure must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs (DCCA), Professional and Vocational Licensing Division at

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	2 of 21

<http://www.chawaii.gov/serv/pvl> to ensure that practitioner is licensed in the State of Hawaii.

2. Primary verification of CAMHD Credentialing requirements as outlined in the “*CAMHD Licensed Provider Initial Credentialing (LPIC) Checklist*” must be satisfied by using acceptable verification methods within the specified timelines. (See Attachment 2)

C. Policies and Procedures

1. Process used to making credentialing and recredentialing decisions.
 - a. The credentials of applicants are evaluated against pre-determined criteria in conjunction with the National Committee of Quality Assurance (NCQA) and state licensing requirements. This policy outlines the criteria used to approve applicants.
 - b. The “*CAMHD LPIC Checklist*” incorporates these criteria to facilitate auditing of primary source verifications in the practitioner’s credential chart.
 - c. Committee members are required to use their professional and personal knowledge of the applicant’s business practices, ethics, and ability to provide quality services to CAMHD consumers in a safe treatment environment in the decision making process.

2. Non-Discrimination

The CAMHD Credentialing Committee does not make credentialing decisions based solely on the applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients the practitioner (e.g., Medicaid) specializes in.

3. The process of notification to a practitioner of any information obtained during the credentialing process that varies substantially from the information provided to CAMHD and or the CAMHD Contracted Provider Agency (CAMHD Agency) by the provider:

CAMHD and or the CAMHD Agency must notify the applicant of any information obtained during the credentialing process vary substantially from the information provided to them in writing via regular mail. The applicant must respond within 15 business days from the date of the notification letter with a letter of explanation for the varying information. Additional documents may be submitted to CAMHD and or the CAMHD Agency to substantiate or explain the variations. CAMHD has 15 business days from the date of receipt of the letter of explanation to review

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	3 of 21

Documents and render a decision. The decision letter includes the reconsideration and appeal process stated below.

4. The Request for Reconsideration & Appeal Process
 - a. If the applicant does not agree with the CAMHD Credentialing Committee's decision, they have the right to request for reconsideration. Reconsideration requests must be submitted with additional documentation to support the request. These must be received at CAMHD within 15 business days from the decision letter, unless otherwise stated.
 - b. The CAMHD Credentialing Committee will review the submitted documents and issue a reconsideration decision to the applicant or through the CAMHD Agency via facsimile or mail within fifteen (15) business days from the date of receipt of the reconsideration request.
 - c. The applicant, either directly or through the CAMHD Agency, has the option to file a formal complaint with CAMHD's Grievance Office at 733-8495 in the event the CAMHD Credentialing Committee holds to its original decision.
5. The process to ensure that practitioners are notified of the credentialing or re-credentialing decision within sixty (60) calendar days of the committee's decision:

A CAMHD Credentialing Committee letter is sent to the applicant through the CAMHD Agency within fifteen (15) business days of the decision. If the applicant does not agree with the decision they are entitled to request for reconsideration through the "*Request for Reconsideration & Appeal Process*" outlined above.
6. The medical director or other designated health care professional's direct responsibility and participation in the CAMHD credentialing program:
 - a. The CAMHD Credentialing Committee Chairman, a Medical Director from one of CAMHD's Family Guidance Centers, has direct oversight of the CAMHD Credentialing program. His primary role is to ensure that the committee functions within its defined role, evaluates its projected goals through committee approved performance measures, as well as report the committee's activities and accomplishments to the CAMHD Performance Improvement Steering Committee.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	4 of 21

- b. The CAMHD Medical Director sits in the CAMHD Credentialing Committee as an ex-officio member to provide guidance and feedback to the committee.

7. The process used to ensure confidentiality of all information obtained in the credentialing process, except otherwise provided by law:

The CAMHD Credentialing Committee and CAMHD Contracted Provider Agencies' Credentialing Specialists and other personnel that have access to credential information must sign the "*CAMHD Credentialing Committee Member Confidentiality Form*" to ensure confidentiality of all information gathered during the credentialing process, except otherwise provided by law, and are used for the sole purpose of credentials evaluation. (See Attachment 3) In addition, any discussions held during the CAMHD Credentialing Committee must remain confidential except when otherwise provided by law.

8. The process to delegate credentialing and recredentialing.

The primary source verification portion of the credentialing process is delegated to the CAMHD Agencies for their employees and subcontractors. This function is delegated to a contracted credentialing verification service for CAMHD employees and contractors. Refer to the "*CAMHD Credentialing Delegation Policies and Procedures*" for specific delegated activities and CAMHD monitoring of those activities.

D. Practitioner Rights

1. The right of practitioner's right to review submitted information in support of their credentialing applications:

The following statement is included in the "*CAMHD Licensed Provider Initial Credentialing Application Form*" (See Attachment 4) to notify them of this right:

- a. The applicant has the right to request and review primary source verifications obtained on their behalf. A written request must be sent to the CAMHD Credentialing Specialist, CAMHD Credentialing Unit, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816.
- b. The CAMHD Credentialing Unit has 30 days to forward copies of primary source documents to the applicant via regular mail. In the event that the primary source verification function has been delegated to the CAMHD Agency, the written request must be sent to the attention of the CAMHD Agency Credentialing Specialist.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	5 of 21

- c. The CAMHD Agency Credentialing Specialist has 30 days to forward the copies of the primary source documents to the applicant via regular mail.
2. The practitioner's right to correct erroneous information:
 - a. In the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner, CAMHD must notify the applicant in writing within 15 business days from date of discovery. Notification may be sent directly to the applicant or through the CAMHD Agency Credentialing Specialist.
 - b. The applicant has the right to correct erroneous information by sending a letter directly to the CAMHD Credentialing Committee to the following address: CAMHD Credentialing Specialist, CAMHD Credentialing Unit, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816 or through the CAMHD Agency in writing within 15 business days from date of receipt of the notification letter from CAMHD. Additional documents may be submitted to CAMHD and or the CAMHD Agency to substantiate or explain the erroneous information.
 - c. CAMHD has thirty (30) days from the date of receipt of the letter of explanation to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated in the "*Request for Reconsideration & Appeal Process*" section of this policy.
3. The right of practitioners, upon request, to be informed of the status of their credentialing or recredentialing application.
 - a. The applicant has the right to request, in writing or through telephone, the status of their credentialing or recredentialing application. CAMHD must respond to such inquiry within ten (10) business days either in writing, through telephone, or electronic mail.
 - b. Applicants may not review peer-review protected information, references, and letters or recommendations.
4. Notification of provider rights.

The applicants are notified of their rights through the CAMHD Licensed Provider Initial Credentialing Application Form. (See Attachment)

II. Credentialing Committee

A. The Credentialing Committee

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	6 of 21

The standing Child and Adolescent Mental Health Division (CAMHD) credentialing committee is designated to provide oversight over CAMHD's credentialing processes. The committee consists of the following CAMHD standing members:

- A Clinical Director from one of the Family Guidance Centers who serves as the chair;
- The CAMHD Medical Director (ex-officio), the CAMHD credentialing Specialist (ex-officio);
- A Clinical Psychologist from the Clinical Services Office, another Psychologist from one of the Family Guidance Centers;
- A Psychiatrist from one of the Family Guidance Center;
- Social Worker from the Performance Management Section;
- The Quality Operations Supervisor who is a Registered Professional Nurse;
- The Child Abuse & Neglect Screening Reviewer; and
- The Provider Relations Specialist.

B. Credentialing Committee Decisions

1. The committee has granted the authority to the CAMHD Credentialing Specialist to conduct a preliminary review of each provider's credentials in accordance with the CAMHD LPIC Checklist to ensure all primary source verifications being submitted meet CAMHD's established criteria. Files that meet established criteria are available at the CAMHD Credentialing Office for the CAMHD Credentialing Committee members to review prior to the scheduled meetings. A list of the names of all these practitioners who meet the established criteria is presented at the next credentialing committee meeting.
2. Practitioners may not provide care to CAMHD consumers until the final approval from the CAMHD Credentialing Committee.
3. CAMHD reserves the right to make the final determination about which practitioners may participate in its network. If unfavorable information is obtained for a practitioner during the credentialing process, CAMHD reserves the right to ask for additional information and render a decision to approve the provider with or without restrictions or disapprove the provider. The decision letter includes the reconsideration and appeal process stated in the "*Request for Reconsideration & Appeal Process*" section of this policy.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	7 of 21

4. The reasons for those providers that did not meet the criteria will be discussed during the committee meeting. The applicant will be notified either directly or through the CAMHD Agency of the deficiencies and corrective action requested through regular or electronic mail. The response deadline will be included in the notification.
5. The CAMHD Credentialing Committee has CAMHD has 30 days from the date of receipt of the letter of explanation to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated in the “*Request for Reconsideration & Appeal Process*” section of this policy.

III. Initial Credentialing

A. Method of Verification

1. CAMHD or its CAMHD Agencies may use oral, written, and Internet website data to verify information. Oral verifications require a note stating the date of verification, the name of the person from the primary source who verified the information, the name and dated signature of the CAMHD or CAMHD Agency staff that verified the information.
2. Internet website verification requires the dated signature of the CAMHD or CAMHD Agency staff that conducted the query on all printed pages. Written verifications may take the form of a letter that is received via regular mail or facsimile.

B. Verification Time Limit

To prevent the CAMHD Credentialing Committee from considering a provider whose credentials may have changed since they were verified, primary source verification should be no more than 180 days old (unless otherwise stated) at the time of the credentialing committee decision. For written verifications, the 180-daytime limit begins with the date that the credentials were verified (the date on the letter or the signature date) not when CAMHD or the CAMHD Agency received the information.

C. Credentialing Cycle

The two-year credentialing cycle begins with the date of the initial credentialing decision. Providers are considered credentialed after the committee has made its decision. Once providers are credentialed, they are able to carry their full credential status for all CAMHD Agencies. They are not required to be recredentialed every time they change employment as long as it occurs within the two year approved timeframe. There are requirements for interagency credential status transfer. Refer to the Interagency Transfer section of this policy for those requirements.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	8 of 21

D. Practitioner Termination and Reinstatement

1. If a CAMHD or CAMHD Agency employee or subcontractor is voluntary or involuntarily terminated and the practitioner wishes to be reinstated, the practitioner must again be initially credentialed if the break in service is 30 days or more. CAMHD and/or the CAMHD Agency must re-verify credential factors that are no longer within the credentialing time limits. The CAMHD Credentialing Committee must review all credentials and makes a final determination prior to the practitioner's re-entry into the organization.
2. An interagency transfer is allowed after termination provided it is within 30 days of the termination date and there are no negative incidents that led to the termination from the previous CAMHD Agency. The CAMHD Credentialing Committee must review presented facts and makes a final determination prior to the practitioner's re-entry into the organization.

E. CAMHD Network Participation Requirements

To be eligible to become a member of the CAMHD network provider, the applicant must be an employee or direct contractor of CAMHD or an employee or subcontractor of a CAMHD Agency.

F. Initial Credentialing Documents and Primary Source Verification Requirements

The CAMHD LPIC Checklist outlines the CAMHD required primary source verifications, verification timeline requirements, and methods of accepted primary source verification including the following criteria items:

1. Attestation Letter

Verification time limit: 180 days

The CAMHD Agency or CAMHD designated primary source verification agency representative must complete the "*CAMHD Attestation Letter*." (See Attachment 5)

2. License Number

The practitioner's license number must be entered in the CAMHD LPIC Checklist. Verification of the license is done in the license verification portion of the policy.

3. Application Form

Verification time limit: 180 days

All sections of the "*CAMHD Licensed Provider Initial Credentialing Application Form*" must be completed. Work History information may be

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	9 of 21

listed in the resume if not listed in the application form. The application form must include the following items:

- a. Reasons for inability to perform the essential functions of the position, with or without accommodation.

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to CAMHD Credentialing Committee approval.

CAMHD and its Agency must ensure that the following question in the credentialing application form contains a “No” answer:

"Do you have any physical and/or mental condition which would interfere with the performance of those privileges which you are requesting and/or the essential functions of the contractual arrangement for which you are applying, with or without accommodation?"

In the event an applicant answers “Yes” a letter of explanation must accompany the application. The CAMHD Credentialing Committee must review the letter of explanation and weigh the implications of any health conditions stated as it pertains to the applicant’s ability to perform the functions of the position that the provider is being credentialed for. The CAMHD Credentialing Committee may consider approval of the applicant with or without restrictions.

- b. Lack of present illegal drug use.

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to CAMHD Credentialing Committee approval.

CAMHD and its Agency must ensure that the restrictive actions questions pertaining to illegal drug use in the credentialing application form contains a “No” answer.

In the event an applicant answers “Yes” a letter of explanation must accompany the application. The CAMHD Credentialing Committee must review the letter of explanation and weigh the implications of any illegal drug use reported as it pertains to the applicant’s ability to perform the functions of the position that the provider is being credentialed for. The CAMHD Credentialing Committee may consider approval of the applicant with or without restrictions.

- c. History of loss of license and felony convictions.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	10 of 21

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to CAMHD Credentialing Committee approval.

CAMHD and its Agency must ensure that the restrictive actions questions pertaining to loss of license and felony convictions in the credentialing application form contains a “No” answer. In addition, the Hawaii Justice Center Check results would also be considered to satisfy the felony conviction verification requirements of this criterion.

In the event an applicant answers “Yes” a letter of explanation must accompany the application. The CAMHD Credentialing Committee must review the letter of explanation and weigh the implications of any loss of license and or felony convictions it relates to the applicant’s ability to perform the functions of the position that the provider is being credentialed for. The CAMHD Credentialing Committee may consider approval of the applicant with or without restrictions.

- d. History of loss or limitation of privileges or disciplinary activity.

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to CAMHD Credentialing Committee approval.

CAMHD and its Agency must ensure that the restrictive actions questions pertaining to limitation of privileges or disciplinary actions in the credentialing application form contains a “No” answer

In the event an applicant answers “Yes” a letter of explanation from the applicant must accompany the application. The CAMHD Credentialing Committee must review the letter of explanation and weigh the implications of any loss or limitation of privileges or disciplinary activity it relates to the applicant’s ability to perform the functions of the position that the provider is being credentialed for. The committee reserves the right to ask for a letter from the applicant’s supervisor and or agency to ensure that proper mechanisms are in place to prevent a similar situation from occurring while practitioner is around CAMHD consumers. The CAMHD Credentialing Committee may consider approval of the applicant with or without restrictions.

- e. Attestation as to the correctness and completeness of the application.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	11 of 21

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to CAMHD Credentialing Committee approval.

The applicant must sign and date the following attestation statement in the application:

“I represent that information provided in or attached to this credentialing application form is accurate. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in the denial of appointment and clinical privileges. In the event of my termination for this reason, I will not be entitled to any hearing, appeal, or other due process rights. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the <NAME OF AGENCY> may immediately terminate my appointment.”

4. Resume

Verification time limit: 180 days

CAMHD does not require primary source verification of work history. A minimum of 5 years of work history must be obtained through the practitioner’s application or resume. If it is obtained from the resume, the resume must state a date of preparation so that the CAMHD Credentialing Committee is able to determine the 180-day time limit for this criterion. The applicant must submit a written explanation of any gaps over 6 months.

5. Education, Residency, Internship, Fellowship, Board Certification

- a. Education and training including board certification if the practitioner states on the application that he/she is board certified.

Verification time limit: None. This means that old verifications would be considered acceptable provided it verifies the education that is applicable to the licensure the applicant is being credentialed for.

CAMHD or the CAMHD Agency must verify only the highest level of credentials attained. If a physician is board certified, verification of that board certification fully meets this element, because specialty boards verify education and training. For practitioners, who are not board certified, verification of completion of residency fully meets this requirement. For those who have not completed a residency

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	12 of 21

program, verification of graduation from medical school meets this standard.

b. Education Verification Requirements for Different Specialties:

For Board Certified Physicians:

Verification of board certification fully meets education verification requirements because medical boards already verify education and training. Separate verification of education and residency training is not required for board certified medical doctors.

For Non-Board Certified Physicians:

Conduct verification by doing one of the following:

Verification of completion of residency training meets this requirement through any of the following primary source verification methods:

- Confirmation from the residency training program.
- Entry in the American Medical Association (AMA) Physician Master File.
- Entry in the American Osteopathic Association (AOA) Physician Master File.

Verification of graduation from medical school through any of the following primary source verification methods:

- Confirmation from the medical school.
- Entry in the American Medical Association (AMA) Physician Master File.
- Entry in the American Osteopathic Association (AOA) Physician Master File.
- Confirmation from the Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates after 1986.

Non-Physician Behavioral Healthcare Professionals

Confirmation from the university specifically stating name of applicant, degree and date conferred. Written verifications must be received directly from the university attended. Telephone verifications are acceptable provided the name of the person

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	13 of 21

verifying the information; the date of verification, and the person's name at the primary source is identified in a memo.

- c. Board certification, if designated by the practitioner on the application.

Verification Time Limit: Any NCQA recognized source is valid up to one year but if it is a document source (e.g. ABMS Compendium), verification must also be based on the most current edition.

If an applicant states in their application form that they are board-certified, the board certification must be queried. Acceptable methods of verification includes any of the following:

Physicians

Completion of one of these:

- Entry in the ABMS Compendium.
- Entry in the AOA Physician Master File.
- Entry in the AOA Directory of Osteopathic Physicians.
- Entry in the AMA Master File.
- Confirmation from the specialty board

Non-Physician Behavioral Healthcare Professionals

Confirmation from the specialty board

Foreign Trained Physicians

Foreign trained physicians that graduated and obtained licensed after 1986 must submit a copy of their ECFMG certificate.

6. Controlled Substance Certificates

Verification time limit: Certificate must be effective at the time of the credentialing committee decision.

If the applicant is a medical doctor, a copy of the current DEA and state NED certificate must be present at the time of credentialing approval.

A provider with a pending DEA application may be credentialed provided that another practitioner with a valid DEA certificate write all prescriptions requiring a DEA number for the practitioner until the practitioner has a valid DEA certificate. The name of the practitioner with the valid DEA number must be noted clearly on the credentialing file of the provider without a DEA number.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	14 of 21

7. Malpractice Insurance

- a. Current malpractice insurance coverage.

Verification time limit: Coverage must be effective at the time of the credentialing decision.

CAMHD and / or its Agency must obtain a letter confirming current malpractice coverage from the insurer. The letter must state the name of the provider, policy number, dates of coverage, and 1 million / 3 million aggregate of coverage. Copies of face sheets from the practitioner will not satisfy this requirement unless it has been received from the insurer.

- b. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

Verification time limit: 180 days

CAMHD or its Agency must obtain written confirmation of malpractice settlements from the current malpractice carrier and for all malpractice carriers in the past 10 years. These years may include residency years. In some instances, practitioners may have been covered by a hospital insurance policy during residency. In these cases, CAMHD or its Agency does not need to obtain confirmation from the carrier.

8. State of Hawaii License Verification

Verification time limit: 180 days

- a. Applicant possesses a current license to practice in the State of Hawaii.

CAMHD must confirm that the applicant holds a valid, current State of Hawaii license to practice. The license must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at <http://www.ehawaii.gov/org/serv/pvl>. A printout of the license must be completed. The person conducting the query must date and sign all the pages of the printout results.

- b. State sanctions, restrictions on licensure and or limitation on scope of practice.

The practitioner's license limitations and restrictions must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	15 of 21

Licensing Division at <http://www.ehawaii.gov/org/serv/pvl> A printout of the complaints history must be completed. The person conducting the query must date and sign all the pages of the printout results.

9. Medicare/Medicaid Sanctions

Verification time limit: On-site audit conducted within 180 days

The Office of the Inspector General at <http://exclusions.oig.hhs.gov/search.html> must be queried for the existence of any Medicare/Medicaid sanctions against the applicant. A printout of the results must be done. The person conducting the query must initial all printout results. The query results must indicate “no records” query result. In the event that there is a record on file, the applicant must provide a letter of explanation of the record. The committee will review the implications of the record as it pertains to the applicant’s ability to provide quality services to CAMHD consumers.

10. Hawaii Justice Center Data Bank Verification:

The Hawaii Justice Center Data Bank must be queried for any criminal record. The query results must indicate “no records found”. In the event that a record is found within the past ten (10) years, the applicant must provide a written explanation of the record. Rehabilitative or self-improvement programs attended to help improve whatever issues there may be at the time of offense shall be listed. In addition, the CAMHD Agency must also submit to CAMHD a written supervision plan that outlines the position and overall function of the applicant, supervision structure, and any other mechanisms in place to prevent similar offenses from occurring while the applicant is employed with the CAMHD Agency or around CAMHD consumers. Traffic violations that are non-alcohol related do not need a letter of explanation provided that the practitioner does not drive CAMHD consumers.

11. National Practitioner Data Bank Query

Verification time limit: 180 days

The National Practitioner Data Bank (NPDB) must be queried for previous malpractice claims history and or state licensure sanctions. CAMHD, its Agency or its delegated primary source verification contractor must become registered users of the NPDB to be able to request verifications. The query results must indicate “no records” query result. In the event that there is a record on file, the applicant must provide a letter of explanation of the record. The committee will review the implications of the record as it

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	16 of 21

pertains to the applicant's ability to provide quality services to CAMHD consumers.

12. Child and Abuse Neglect Verification.

Verification time limit: 180 days

The Department of Human Services Child Protective Services Database would be queried for child abuse and neglect records. The "*CAMHD CAN Request Form*" and "*CAMHD CAN Authorization Form*" must be completed. (See Attachments 6 & 7) The query results must indicate "no records found". In the event that a record is found, CAMHD must notify the applicant or its Agency of the record. Please refer to the generic "*CAMHD CAN Negative Result Check Generic Letter*". (See Attachment 8)

IV. Initial Credentialing Site Visits

1. Performance Standards and Thresholds

Time Limit: On-site audit conducted within 180 days of credentialing approval

a. Treatment Office Evaluation

The "*CAMHD Treatment Office Visit*" tool would be used for this review. A designated CAMHD staff will conduct the onsite visit. (See Attachment 9) A minimum score of 80% for the office site section is required. For practitioners providing services in a special treatment facility (STF) or therapeutic group home (TGH), the license to operate issued to the agency by the Office of Health Care Administration (OHCA) will be accepted as verification that the facility is in compliant with all state laws pertaining to the type of service.

b. Treatment Record-keeping Practices

The "*CAMHD Treatment Office Visit*" tool would be used for this review. A designated CAMHD staff will conduct the onsite visit since. The review of medical record-keeping practices does not have to include clinical elements during the initial visit; therefore, clinical personnel do not need to conduct the site visit. A minimum score of 80% for the office site section is required.

c. Medication Storage and Log Requirements

The "*CAMHD Treatment Office Visit*" tool would be used for this review. A designated CAMHD staff will conduct the onsite visit since. The review of medication storage and log practices does not have to include clinical elements during the initial visit; therefore,

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	17 of 21

clinical personnel do not need to conduct the site visit. A minimum score of 80% for the office site section is required.

d. Availability of Emergency Equipment

The “*CAMHD Treatment Office Visit*” tool would be used for this review. A designated CAMHD staff will conduct the onsite visit since. The review of medical record-keeping practices does not have to include clinical elements; therefore, clinical personnel do not need to conduct the site visit. A minimum score of 80% for the office site section is required.

2. Identification of high volume practitioners

All providers in the CAMHD network are subject to all the rules set forth in this policy regardless of the volume of CAMHD consumers they treat. Information from the utilization management threshold outliers will be reviewed during re-credentialing.

3. New Practitioner joins existing site

An additional site visit is not necessary when a new practitioner joins and office site that has already has a site visit and is part of the CAMHD Agency, provided the site visit was conducted within the 180 days of the new practitioner's approval. When a new practitioner joins an existing office site, CAMHD will include documentation of the site visit for that office in the new practitioner's credentialing file. This documentation must be in the file prior to the CAMHD credentialing committee decision.

4. Relocations and additional sites

When notified upon any agency's application to open a new site, the CAMHD Credentialing Specialist will conduct a site visit. Instances when CAMHD must visit new sites include, but are not limited to when a practitioner opens an additional office or moves to offices from one location to another.

5. Follow-Up Actions for Initial Onsite Visit Findings / Deficiencies

a. Reporting of Initial Onsite Audit Deficiencies and Corrective Action Activities

If the provider scores lower than 80% on any of the criteria in the “Treatment Office Visit” during the initial visit, the CAMHD staff conducting the visit will request for a corrective action plan from the practitioner through the CAMHD Agency during the exit interview. A written notification will also be sent to the practitioner through the CAMHD Agency via regular mail or electronic mail.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	18 of 21

Credentialing of the practitioner will be deferred until all deficiencies in the onsite visit are addressed and a score of 80% or higher is obtained.

Corrective action plans or other required documents must be submitted to the CAMHD Credentialing Specialist no later than 30 days from the date of onsite visit. CAMHD will review the corrective action plan and submitted documents. All primary source verifications in the deferred file would have to be within acceptable timelines at the time of review and approval by the CAMHD Credentialing Committee.

b. Follow-up Onsite Visit

CAMHD reserves the right to conduct a follow up onsite visit prior to approving the practitioner to ensure that initial deficiencies noted are now within acceptable thresholds.

6. Ongoing Monitoring of Sanctions and Complaints

a. State sanctions or limitations on licensure

On a yearly basis, at the time of provider network reporting to the Med-QUEST Division, the status of practitioner's State of Hawaii licensure, sanctions, or limitations thereof are verified. In addition, CAMHD compiles all listing of Medicaid suspended or terminated providers letters from the Med-Quest Division. In the event that the name being reported by Medicaid is a current member of the CAMHD provider network, the issue will be brought to the CAMHD Credentialing Committee within 24 hours of receipt to conduct an emergency meeting to formalize the suspension or termination of the provider from the network.

b. Grievance Office

Information from the CAMHD Grievance Office regarding a specific provider is reported to the Credentialing Unit of the complaint. A brief synopsis of the complaint is included in the notification. The Performance Management Section will conduct an investigation and report their findings to the CAMHD Credentialing Committee. The CAMHD Credentialing Committee will review the recommendations and make its final determination whether to suspend or permanently terminate the practitioner's credentialing status.

c. Sentinel Events Office

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	19 of 21

Information from the CAMHD Sentinel Events Office regarding specific provider is reported to the Credentialing Unit. The nature of the event is included in the notification. The Performance Management Section will conduct an investigation and report their findings to the CAMHD Credentialing Committee. The CAMHD Credentialing Committee will review the recommendations and make its final determination whether to suspend or permanently terminate the practitioner's credentialing status.

d. Medical Suspension/Termination Rights

Information from the Medicaid Suspension/Termination Report is reviewed to determine if the practitioner applicant has been previously suspended or terminated from Medicaid Programs participation. If the practitioner's name is found in the list, the information will be reported to the CAMHD Credentialing Committee for discussion and decision.

7. Notification to Authorities and Practitioner Appeal Rights

a. Range of actions

CAMHD reserves the right to rescind the full credentialing status of any practitioner that does not comply with State Ethics Standards, CAMHD standards, and State and Federal laws.

b. Reporting of serious quality deficiencies that could result in a practitioner's suspension, termination, and/or reporting to appropriate authorities.

Discovery of any misrepresentation of credentials or other illegal activities will be discussed in the CAMHD Credentialing Committee meeting. Results of the discussion may warrant reporting the clinician's name and situation and will be referred to the CAMHD Compliance Committee for investigation, with a copy to the Provider Relations Officer. If warranted, licensed clinician's name may be referred to the designated Medicaid Investigator. CAMHD reserves the right to retain, suspend, or terminate any clinician that has misrepresented his or her credentials in any way that compromises services to the CAMHD children.

The CAMHD Fraud and Abuse Program outlines CAMHD's procedure for reporting serious quality deficiencies that could result in a provider's suspension or termination to the Medicaid Fraud Investigator as well as other appropriate authorities.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	20 of 21

- c. CAMHD has an appeals process for instances in which it chooses to alter the conditions of the practitioner's participation based on issues of quality of care and/or service.

The *"Request for Reconsideration & Appeals Process"* applies for at any time the applicant disagrees with the CAMHD Credentialing Committee Decision. This process is included in all decision letters.

8. Interagency Transfer of Credential Status

Clinician transfers occurring during active credentialing periods shall require verification of items within timeframes as listed in *"CAMHD Licensed Provider Interagency Transfer Checklist"* as applicable. (See Attachment 11) The CAMHD Credentialing Committee has authorized the CAMHD Credentialing Specialist to approve transfers if all criteria are satisfied. The names of the providers approved to transfer will be reported in the next CAMHD Credentialing Committee meeting and the Credentialing

9. MIS Registration of Credentialed Practitioner

All approved practitioner credential information are reported on a weekly basis by the CAMHD Credentialing Unit to CAMHD MIS to be registered in accordance to the established MIS clinician registration guidelines.

10. Credentialing Reports

a. Medicaid Reports

CAMHD must submit to the Department of Human Services Med-QUEST Division (DHS-MQD) a bi-yearly listing of its provider network. At a minimum, the list must include the name of the provider, their title, site address, and telephone number.

b. CAMHD Performance Improvement Steering Committee (PISC) Reports

The CAMHD Credentialing Committee must submit to PISC for review its performance measures for timeliness, quality, and effectiveness on a monthly basis. A representative from the Credentialing Committee attends the PISC meetings.

ATTACHMENTS:

1. CAMHD Glossary of Credentialing Terms - July 17, 2003

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Credentialing of Licensed Health Care Professionals	Number:	80.308
	Page:	21 of 21

2. CAMHD Licensed Provider Initial Credentialing Checklist, Rev. 7-10-03
3. CAMHD Credentialing Committee Member Confidentiality Form; Version July 2003
4. CAMHD Attestation Letter
5. CAMHD Licensed Provider Initial Credentialing Application Form, Rev. 7-11-03
6. CAMHD CAN Request Form, Rev. 7-11-03
7. CAMHD CAN Authorization Form, Rev. 7-11-03
8. CAMHD CAN Negative Findings Generic Letter Format
9. CAMHD Treatment Office Visit Tool; Rev. 7-10-03
10. CAMHD Licensed Provider Interagency Transfer Checklist; Rev. 7-10-03

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	1 of 21
REFERENCE: HRS; HI QUEST; QARI; HI Stte; 42 CFR; Licensing Boards; CMS; CAMHD QAIP; NCQA; HSAG Audit Tool	APPROVED:	
	<i>Signature on File</i> Chief	15 Jul 03 Eff. Date

PURPOSE

To assure competent, safe, and effective practices by licensed qualified mental health professionals serving Child and Adolescent Mental Health Division (CAMHD) consumers.

DEFINITIONS

See Glossary of Credentialing Terms (**Attachment 1**)

POLICY

I. Credentialing Policies

- A. Any State of Hawaii licensed practitioner considered by CAMHD as a QMHP that either, is employed with CAMHD, has an independent contract with CAMHD or is employed or subcontracted by a CAMHD contracted provider agency (Agency), exclusive of hospital in patient contracts, is covered under this policy.
- B. Re-credentialing of the following State of Hawaii Licensed practitioners are covered under this policy: Medical Doctor (M.D.), Licensed Social Worker (LSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist (Ph.D. or Psy.D.), Advanced Practice Registered Nurse (APRN), and Osteopathic Doctor (D.O.).
 1. Licensed Practitioners that do not need to be credentialed:
 - a. Practitioners who practice exclusively within the inpatient setting and who provide care for CAMHD consumers only as a result of the consumers being directed to the hospital or another inpatient setting. These practitioners need to be credentialed by the hospital or the inpatient setting they provide the services.
 - b. Practitioners who do not provide care for CAMHD consumers in a treatment setting (consultants).
- C. Criteria and Primary Source Verification used to satisfy criteria:
 1. State of Hawaii licenses must be primary source-verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division (DCCA) at <http://www.ehawaii.gov/serv/pvl> to ensure that practitioners are licensed in the State of Hawaii.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	2 of 21

2. Primary verification of CAMHD Credentialing requirements as outlined in the “*CAMHD Licensed Provider Re-credentialing Checklist*” must be satisfied by using acceptable verification methods within the specified timelines. **(See Attachment 2)**

D. Policies and Procedures

1. CAMHD shall used the following processes to determine credentialing and recredentialing decisions:
 - a. The CAMHD Credentialing Committee (Committee) shall evaluate the credentials of each applicant against pre-determined criteria in conjunction with National Commission of Quality Assurance (NCQA) and state licensing requirements.
 - b. The predetermined criteria listed in the “*CAMHD Licensed Provider Re-credentialing Checklist*” shall facilitate auditing of primary source verified documents in the practitioner’s credential chart.
 - c. The Committee members shall use their professional and personal knowledge of the applicant’s business practices, ethics, and ability to provide quality services to CAMHD consumers in a safe treatment environment in the decision making process.
2. Non-discrimination

The Committee does not make credentialing decisions based on the applicant’s race, ethnic / national identity, gender, age, sexual orientation, or the types of procedures or types of patients the practitioner (e.g., Medicaid) specializes in.
3. The CAMHD shall notify the practitioner via regular mail of any information obtained during the credentialing process that varies substantially from the information provided to CAMHD and or to the Agency by the practitioner.
 - a. The applicant must respond within fifteen (15) business days from the date of receipt of the notification letter with a *letter of explanation* explaining the discrepancy or variance. Additional documents may be submitted to CAMHD and or its Agency to substantiate or explain the variations.
 - b. CAMHD has fifteen (15) business days from the date of receipt of the applicant’s *letter of explanation* to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated below.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	3 of 21

4. The *Request for Reconsideration & Appeal Process*
 - a. If an applicant does not agree with the Committee's decision, he/she may request a re-consideration.
 - b. Re-consideration requests must be submitted with additional documentation of new information to support the request.
 - c. The applicant must submit any additional documents to CAMHD within fifteen (15) business days from the decision letter, unless otherwise stated.
 - d. The Committee will review the submitted documents and issue a reconsideration decision to the applicant or through the Agency via facsimile or mail within fifteen (15) business days from the date of receipt of the reconsideration request.
 - e. The applicant, either directly or through the Agency, has the option to file a formal complaint with CAMHD's Grievance Office (GO) at 733-8495 in the event the Committee holds to its original decision.
5. The process to ensure that notified applicants have the credentialing or re-credentialing decision within sixty (60) calendar days of the Committee's decision.
 - a. A Committee *letter of decision* shall be sent to the applicant through the Agency within fifteen (15) business days of the decision.
 - b. If the applicant does not agree with the decision he/she is entitled to request for reconsideration through the "*Request for Reconsideration & Appeal Process*" outlined above.
6. The medical director or other designated health care professional's direct responsibility and participation in the CAMHD credentialing program:
 - a. The Committee Chairman, a Clinical Director from one of CAMHD's Family Guidance Centers (FGC), has direct oversight of the CAMHD Credentialing program.
 - b. His primary role shall be to ensure that the committee functions within its defined role, evaluates its projected goals through committee-approved performance measures, as well as to report the committee's activities and accomplishments to the CAMHD Performance Improvement Steering Committee (PISC).

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	4 of 21

- c. The CAMHD Medical Director sits on the Committee as an ex-officio member to provide guidance and feedback to the committee.
- 7. The process used to ensure confidentiality of all information obtained in the re-credentialing process, except otherwise provided by law.
 - a. The Committee and CAMHD Agencies' Credentialing Specialists and other personnel that have access to credential information must sign the "*CAMHD Credentialing Committee Member Confidentiality Form*" to ensure confidentiality of all information gathered during the re-credentialing process, except otherwise provided by law, used for the sole purpose of credentials evaluation. **(See Attachment 3)**
 - b. In addition, any discussions held during the Committee shall remain confidential except when otherwise provided by law.
- 8. The process to delegate re-credentialing include:
 - a. The primary source verification portion of the re-credentialing process is delegated to the Agency for their employees and subcontractors.
 - b. This function is delegated to a contracted credentialing verification service for CAMHD employees and contractors.
 - c. Refer to the "*CAMHD Credentialing Delegation Policies and Procedures*" for specific delegated activities and CAMHD monitoring of those activities.
- E. Practitioner Rights
 - 1. The practitioner has the right to review submitted information in support of his/her credentialing application.

The following statement is included in the "*Licensed Provider Re-credentialing Application Form*" **(See Attachment 4)** to notify the applicant of this right:

 - a. The applicant has the right to request and review primary source verifications obtained on their behalf. A written request must be sent to the CAMHD Credentialing Specialist, CAMHD Credentialing Unit, 3627 Kilauea Avenue, Room 101, Honolulu, Hawaii 96816.
 - b. The CAMHD Credentialing Specialist has thirty (30) days to forward copies of primary source documents to the applicant via

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	5 of 21

regular mail. In the event that the primary source verification function has been delegated to the Agency, the written request must be sent to the attention of the Agency Credentialing Specialist.

- c. The CAMHD Credentialing Specialist has thirty (30) days to forward the copies of the primary source documents to the applicant via regular mail.
2. The practitioner has the right to correct erroneous information.
 - a. In the event that credentialing information obtained from other sources varies substantially from that provided by the applicant, CAMHD must notify the applicant in writing within fifteen (15) business days from date of discovery. Notification may be sent directly to the applicant or through the Agency Credentialing Specialist.
 - b. The applicant has the right to correct erroneous information by sending a letter directly to the Committee to the following address: CAMHD Credentialing Specialist, CAMHD Credentialing Unit, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816 or through the CAMHD Agency in writing within 15 business days from date of receipt of the notification letter from CAMHD. Additional documents may be submitted to CAMHD and or its Agency to substantiate or explain the erroneous information.
 - c. CAMHD has thirty (30) days from the date of receipt of the letter of explanation to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated in the “*Request for Reconsideration & Appeal Process*” section of this policy.
 3. The practitioner has the right, upon request, to be informed of the status of his/her credentialing or recredentialing application.
 - a. The applicant has the right to request, in writing or through telephone, the status of his/her credentialing or recredentialing application. The CAMHD Credentialing Specialist must respond to such inquiry within ten (10) business days either in writing or through telephone.
 - b. The applicant may not review peer-review protected information, references, and letters or recommendations.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	6 of 21

4. Notification of practitioner's rights shall be included in the credentialing application form.

II. Credentialing Committee

A. The Credentialing Committee

The Credentialing Committee is a CAMHD standing committee designated to provide oversight over CAMHD's credentialing processes. The Committee shall consist of the following standing members:

- Clinical Director from one of the Family Guidance Centers who serves as the chair;
- CAMHD Medical Director (ex-officio);
- CAMHD Credentialing Specialist (ex-officio);
- Clinical Psychologist from the Clinical Services Office;
- Psychologist from one of the Family Guidance Centers;
- Psychiatrist from one of the Family Guidance Center;
- Social Worker from the Performance Management Section;
- Quality Operations Supervisor who is a Registered Professional Nurse
- Child Abuse & Neglect Screening Reviewer; and
- Provider
- Relations Specialist.

B. Credentialing Committee Decisions

1. The Committee may grant authority to the CAMHD Credentialing Specialist to conduct a preliminary review of each practitioner's credentials in accordance with the "CAMHD *Licensed Provider Re-credentialing Checklist*" to ensure all primary source verifications being submitted meet CAMHD's established criteria. The CAMHD Credentialing Specialist shall:
 - a. Make available applicant files that meet established criteria at the Credentialing Unit office for the Committee members to review prior to the scheduled meetings.
 - b. Submit the list of the applicants who meet the established criteria at the next Committee meeting.
2. If re-credentialing did not occur prior to the expiration of the initial credentialing date the practitioner may not see consumers until the date of final approval from the Committee.
3. CAMHD reserves the right to make the final determination about which practitioners may participate in its network. If unfavorable information is obtained about a practitioner during the credentialing process, CAMHD

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	7 of 21

reserves the right to ask for additional information and render a decision to approve the practitioner with or without restrictions or to disapprove the practitioner with reasons as discussed during the Committee meeting. The *decision letter* shall include the reconsideration and appeal process as stated in the “*Request for Reconsideration & Appeal Process*” section of this policy.

4. The applicant will be notified either directly or through the Agency of the deficiencies and corrective action requested through regular or electronic mail. The response deadline shall be included in the *decision letter*.
5. The Committee has thirty (30) days from the date of receipt of the *letter of explanation* to review documents and render a decision. The *decision letter* includes the rationale for the decision and the reconsideration and appeal process stated in the “*Request for Reconsideration & Appeal Process*” section of this policy.

III. Re-credentialing

A. Method of Verification

1. CAMHD or its Agencies may use oral, written, and Internet website data to verify information. Oral verifications require a note stating the date of verification, the name of the person from the primary source who verified the information, the name and dated signature of the CAMHD or its Agency staff that verified the information.
2. Internet website verification requires the dated signature of the CAMHD or its Agency staff that conducted the query on all printed pages. Written verifications may take the form of a letter that is received via regular mail or facsimile.

B. Verification Time Limit

To prevent the Committee from considering a practitioner whose credentials may have changed since they were last verified, primary source verification must be no more than 180 days old (unless otherwise stated) at the time of the credentialing committee decision. For written verifications, the 180-day time limit begins with the date that the credentials were verified (the date on the letter or the signature date) not when CAMHD or the Agency received the information.

C. Re-credentialing Cycle

Upon approval of re-credentialing, the two (2)-year full approval cycle begins. Practitioners are considered re-credentialed after the committee has made its decision. Once a practitioner is re-credentialed, they are able to carry their full re-credentialed status for all CAMHD Agencies. They are not required to be re-

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	8 of 21

credentialed every time they change employment as long as it occurs within the two year approved timeframe. There are requirements for interagency credential status transfer. Refer to the Interagency Transfer section of this policy for those requirements.

D. Practitioner Termination and Reinstatement

1. If a CAMHD or its Agency employee or subcontractor is voluntary or involuntarily terminated and the practitioner wishes to get reinstated, the practitioner must again be initially credentialed if the break in service is thirty (30)-days or more. CAMHD and/or the Agency must re-verify credential factors that are no longer within the credentialing time limits. The Committee must review all credentials and make a final determination prior to the practitioner's re-entry into the organization.
2. An interagency transfer is allowed after termination provided it is within thirty (30)-days of the termination date and there are no negative incidents that led to the termination from the previous CAMHD Agency. The Committee must review presented facts and make a final determination prior to the practitioner's re-entry into the organization.

E. CAMHD Network Participation Requirements

To be eligible to become a member of the CAMHD Provider Network, the applicant must be an employee or direct contractor of CAMHD or an employee or subcontractor of an Agency.

F. Re-credentialing Documents and Primary Source Verification Requirements

The "CAMHD *Licensed Provider Re-credentialing Checklist*" outlines the CAMHD required primary source verifications, verification timeline requirements, and methods of accepted primary source verification including the following criteria items:

1. Attestation Letter

Verification time limit: 180 days

The Agency or CAMHD designated primary source verification agency representative must complete the "CAMHD *Attestation Letter*".

2. License Number

The practitioner's license number must be entered in the CAMHD "Licensed Provider *Initial Re-credentialing Checklist*." Verification of the license is done in the license verification portion of the policy.

3. Application Form

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	9 of 21

Verification time limit: 180 days

All sections of the “CAMHD Licensed Provider Re-credentialing Application Form” must be completed. Work History information may be listed in the resume in lieu of the application form. The application form must include the following items:

- a. Reasons for inability to perform the essential functions of the position, with or without accommodation.

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.

CAMHD and its Agency must ensure that the following question in the credentialing application form contains a “No” answer:

Do you have any physical and/or mental condition which would interfere with the performance of those privileges which you are requesting and/or the essential functions of the contractual arrangement for which you are applying, with or without accommodation?

In the event an applicant answers “Yes” a *letter of explanation* must accompany the application. The Committee must review the letter of explanation and weigh the implications of any health conditions stated as it pertains to the applicant’s ability to perform the functions of the position that the practitioner is being credentialed for. The Committee may consider approval of the applicant with or without restrictions.

- b. Lack of present illegal drug use.

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.

CAMHD and its Agency must ensure that the restrictive actions questions pertaining to illegal drug use in the credentialing application form contains a “No” answer.

In the event an applicant answers “Yes” a letter of explanation must accompany the application. The Committee must review the letter of explanation and weigh the implications of any illegal drug use reported as it pertains to the applicant’s ability to perform the functions of the position that the applicant is being credentialed for.

- c. History of loss of license and felony convictions.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	10 of 21

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.

CAMHD and its Agency must ensure that the restrictive actions questions pertaining to loss of license and felony convictions in the credentialing application form contains a “No” answer. In addition, the Hawaii Justice Center Check results would also be considered to satisfy the felony conviction verification requirements of this criterion.

In the event an applicant answers “Yes” a letter of explanation must accompany the application. The Committee must review the letter of explanation and weigh the implications of any loss of license and or felony convictions it relates to the applicant’s ability to perform the functions of the position that the applicant is being credentialed for.

- d. History of loss or limitation of privileges or disciplinary activity.

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.

CAMHD and its Agency must ensure that the restrictive actions questions pertaining to limitation of privileges or disciplinary actions in the credentialing application form contains a “No” answer

In the event an applicant answers “Yes” a *letter of explanation* from the applicant must accompany the application. The Committee must review the *letter of explanation* and weigh the implications of any loss or limitation of privileges or disciplinary activity it relates to the applicant’s ability to perform the functions of the position that the applicant is being credentialed for. The Committee reserves the right to ask for a letter from the applicant’s supervisor and or Agency to ensure that proper mechanisms are in place to prevent a similar situation from occurring while practitioner is serving CAMHD consumers.

- e. Attestation as to the correctness and completeness of the application.

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.

The applicant must sign and date the following attestation statement in the application:

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	11 of 21

“I represent that information provided in or attached to this credentialing application form is accurate. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in the denial of appointment and clinical privileges. In the event of my termination for this reason, I will not be entitled to any hearing, appeal, or other due process rights. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the <NAME OF AGENCY> may immediately terminate my appointment.”

4. Resume

Verification time limit: 180 days

CAMHD does not require primary source verification of work history. A minimum of five (5) years of work history must be obtained through the practitioner’s application or curriculum vitae. If it is obtained from the resume, the resume must state a date of preparation so that the Committee is able to determine the 180-day time limit for this criterion. The applicant must submit a written explanation of any *gaps over 6 months*.

5. Education, Residency, Internship, Fellowship, Board Certification if obtained higher education since last credentialed.

- a. Education and training including board certification if the practitioner states on the application that he/she is board certified.

Verification time limit: None. This means that old verifications would be considered acceptable provided it verifies the education that is applicable to the licensure the applicant is being credentialed for.

CAMHD or its Agency must verify *only the highest level* of credentials attained. If a physician is board certified, verification of that board certification fully meets this element, because specialty boards verify education and training. For practitioners, who are not board certified, verification of completion of residency fully meets this requirement. For those who have not completed a residency program, verification of graduation from medical school meets this standard.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	12 of 21

b. Education Verification Requirements for Different Specialties:

For Board Certified Physicians:

Verification of board certification fully meets education verification requirements because medical boards already verify education and training. Separate verification of education and residency training is not required for board certified medical doctors.

For Non-Board Certified Physicians:

Conduct verification by doing one of the following:

Verification of completion of residency training meets this requirement through any of the following primary source verification methods:

- Confirmation from the residency-training program.
- Entry in the American Medical Association (AMA) Physician Master File.
- Entry in the American Osteopathic Association (AOA) Physician Master File.

Verification of graduation from medical school through any of the following primary source verification methods:

- Confirmation from the medical school.
- Entry in the American Medical Association (AMA) Physician Master File.
- Entry in the American Osteopathic Association (AOA) Physician Master File.
- Confirmation from the Educational Commission for Foreign Medical Graduates (ECMFG) for international medical graduates after 1986.

Non-Physician Behavioral Healthcare Professionals

Confirmation from the university specifically stating name of applicant, degree and date conferred. Written verifications must be received directly from the university attended. Telephone verifications are acceptable provided the name of the person verifying the information; the date of verification, and the person's name at the primary source is identified in a memo.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	13 of 21

- c. Board certification, if designated by the practitioner on the application.

Verification Time Limit: Any NCQA recognized source is valid up to one year but if it is a document source (e.g. ABMS Compendium), verification must also be based on the most current edition.

If an applicant states in their application form that they are board-certified, the board certification must be queried. Acceptable methods of verification includes any of the following:

Physicians

Completion of one of these:

- Entry in the ABMS Compendium.
- Entry in the AOA Physician Master File.
- Entry in the AOA Directory of Osteopathic Physicians.
- Entry in the AMA Master File.
- Confirmation from the specialty board

Non-Physician Behavioral Healthcare Professionals

Confirmation from the specialty board.

Foreign Trained Physicians

Foreign trained physicians who graduated and obtained license after 1986 must submit a copy of their ECFMG certificate.

6. Controlled Substance Certificates

Verification time limit: Certificate must be effective at the time of the credentialing committee decision.

If the applicant is a medical doctor, a copy of the current DEA and state NED certificate must be present at the time of credentialing approval.

A practitioner with a pending DEA application may be credentialed provided that another practitioner with a valid DEA certificate write all prescriptions requiring a DEA number for the practitioner until the practitioner has a valid DEA certificate. The name of the practitioner with the valid DEA number must be noted clearly on the credentialing file of the practitioner without a DEA number.

7. Malpractice Insurance

- a. Current malpractice insurance coverage.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	14 of 21

Verification time limit: Coverage must be effective at the time of the credentialing decision.

CAMHD and / or its Agency must obtain a letter confirming current malpractice coverage from the insurer. The letter must state the name of the practitioner, policy number, dates of coverage, and 1 million/3 million aggregate of coverage. Copies of face sheets from the practitioner will not satisfy this requirement unless it has been received from the insurer.

- b. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

Verification time limit: 180 days

CAMHD or its Agency must obtain written confirmation of malpractice settlements from the current malpractice carrier and for all malpractice carriers since last credentialed. These years may include residency years. In some instances, practitioners may have been covered by a hospital insurance policy during residency. In these cases, CAMHD or its Agency does not need to obtain confirmation from the carrier.

8. State of Hawaii License Verification

Verification time limit: 180 days

- a. Applicant possesses a current license to practice in the State of Hawaii

CAMHD must confirm that the applicant holds a valid, current State of Hawaii licensure to practice. The license must be primary source verified with the State of Hawaii DCCA, Professional and Vocational Licensing Division at <http://www.ehawaii.gov.org/serv/pvl>. A printout of the license must be completed. The person conducting the query must date and sign all the pages of the printout results.

9. State sanctions, restrictions on licensure and or limitation on scope of practice.

The practitioner's license limitations and restrictions must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at <http://www.ehawaii.gov.org/serv/pvl>. A printout of the complaints history must be completed. The person conducting the query must date and sign all the pages of the printout results.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	15 of 21

10. Medicare / Medicaid Sanctions

Verification time limit: 180 days

The Office of the Inspector General at <http://exclusions.oig.hhs.gov/search.html> must be queried for the existence of any Medicare / Medicaid sanctions against the applicant. A printout of the results must be done. The person conducting the query must initial all printout results. The query results must indicate “no records” query result. In the event that there is a record on file, the applicant must provide a letter of explanation of the record. The committee will review the implications of the record as it pertains to the applicant’s ability to provide quality services to CAMHD consumers.

11. Hawaii Justice Center Data Bank Verification:

Verification time limit: 180 days

The Hawaii Justice Center Data Bank must be queried for any criminal record. The query results must indicate “no records found”. In the event that a record is found within the past ten (10) years, the applicant must provide CAMHD a written explanation of the record. Rehabilitative or self-improvement programs attended to help improve whatever issues there may be at the time of offense should be listed. In addition, the Agency must also submit to CAMHD a written supervision plan that outlines the position and overall function of the applicant, supervision structure, and any other mechanisms in place to prevent similar offenses from occurring while the applicant is employed with the Agency or around CAMHD consumers. Traffic violations that are not alcohol related do not need a letter of explanation provided that the practitioner does not drive CAMHD consumers.

12. National Practitioner Data Bank Query

Verification time limit: 180 days

The National Practitioner Data Bank (NPDB) must be queried for previous malpractice claims history and or state licensure sanctions. CAMHD or its delegated primary source verification contractor and or the Agency must become registered users of the NPDB to be able to request verifications. The query results must indicate “no records found” query result. In the event that there is a record on file, the applicant must provide a letter of explanation of the record. The committee will review the implications of the record as it pertains to the applicant’s ability to provide quality services to CAMHD consumers.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	16 of 21

13. Child and Abuse Neglect Verification.

Verification time limit: 180 days

The Department of Human Services Child Protective Services Database shall be queried for child abuse and neglect records. The “*CAMHD CAN Request Form*” and “*CAMHD CAN Authorization Form must be completed.* (See **Attachments 5 & 6**) The query results must indicate “*no records found*”. In the event that a record is found, CAMHD must notify the applicant or the Agency of the record. Please refer to the generic “*CAMHD CAN Negative Result Check Generic Letter*” format. (See **Attachment 7**)

IV. Re-credentialing Site Visits

A. Performance Standards and Thresholds

1. Treatment Office Evaluation

The “*Treatment Office Visit Tool*” shall be used for this review. A designated CAMHD staff will conduct the on-site visit. “(See *Attachment 8*) A minimum score of 80% for the office site section is required. For practitioners providing services in a Special Treatment Facility (STF) or Therapeutic Group Home (TGH), the license to operate issued by the OHCA will be accepted as verification that the facility is in compliance with all state laws pertaining to the type of service.

2. Treatment Record-keeping Practices

The “*Treatment Office Visit Tool*” shall be used for this review. A designated CAMHD staff will conduct the onsite visit. A minimum score of 80% for the office site section is required.

3. Medication Storage and Log Requirements

The “*Treatment Office Visit Tool*” shall be used for this review. A designated CAMHD staff will conduct the onsite visit. A minimum score of 80% for the office site section is required.

4. Availability of Emergency Equipment

The “*Treatment Office Visit Tool*” shall be used for this review. A designated CAMHD staff will conduct the onsite visit since. A minimum score of 80% for the office site section is required.

5. Identification of high volume practitioners

All practitioners in the CAMHD network are subject to all the rules set forth in this policy regardless of the volume of CAMHD consumers they

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	17 of 21

treat. Information from the utilization management threshold outliers will be reviewed during re-credentialing.

6. Follow-Up Actions for Annual On-site Visit Findings / Deficiencies

a. Reporting of Annual On-site Audit Deficiencies and Corrective Action Activities

If the practitioner scores lower than 80% on any of the criteria in the “*Treatment Office Visit Tool*” during the initial visit, the CAMHD staff conducting the visit will request a corrective action plan from the practitioner through the Agency during the exit interview. A written notification will also be sent to the practitioner through the Agency via regular mail or electronic mail. Credentialing of the practitioner will be deferred until all deficiencies in the onsite visit are addressed and a score of 80% or higher is obtained. Corrective action plans or other required documents must be submitted to the CAMHD Credentialing Specialist no later than thirty (30) days from the date of onsite visit. CAMHD will review the corrective action plan and submitted documents. All primary source verifications in the deferred file must be within acceptable timelines at the time of review and approval by the Committee.

b. Follow-up On-site Visit

c. CAMHD reserves the right to conduct a follow up onsite visit prior to approving the practitioner to ensure that deficiencies noted are now within acceptable thresholds.

7. Performance Monitoring and Sanctions

a. State sanctions or limitations on licensure

On a yearly basis, at the time of provider network reporting to the Med-QUEST Division, the status of practitioner’s State of Hawaii licensure, sanctions, or limitations thereof are verified. In addition, CAMHD compiles all listing of Medicaid suspended or terminated practitioner’s letters from the Med-Quest Division. In the event that the name being reported by Medicaid is a current member of the CAMHD provider network, the issue will be brought to the Committee within 24 hours of receipt to conduct an emergency meeting to formalize the suspension or termination of the practitioner from the network.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	18 of 21

b. Grievance Office Information

The Grievance Office must be queried for any substantiated complaints against a practitioner since the last credentialing date. “*No complaints*” query results must be noted in the practitioner’s credential file. If there is a complaint, the CAMHD Credentialing Unit must request a copy of the Grievance Office letter of findings. This must be included in the practitioner’s credential file and taken into consideration during the re-credentialing decision-making process as well as an ongoing provider network participation criteria during the period of approved full re-credential participation.

c. Sentinel Events Office Information

The Sentinel Events Office must be queried for reported sentinel events for the specific practitioner. The *Sentinel Event Provider Incident Count Database* in the Credentialing Unit will also be queried to establish any patterns of reported sentinel events during the credential period. This must be included in the practitioner’s credential file and taken into consideration during the re-credentialing decision-making process as well as an ongoing provider network participation criteria during the period of approved full re-credential participation.

d. Performance Monitoring Unit Information

The Performance Monitoring Unit will be queried for any specific quality improvement activities for a specific practitioner that was found to be below acceptable performance standards in their reviews. This information must be taken into consideration during the re-credentialing decision-making process as well as an ongoing provider network participation criteria during the period of approved full credential participation.

e. Utilization Management Information

The CAMHD Utilization Management Section will be queried as part of the re-credentialing process to determine if the practitioner falls within under or above established utilization thresholds.

f. Member Satisfaction Data.

The Member Satisfaction Data results must be reviewed and taken into consideration during the re-credentialing decision-making

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	19 of 21

process as well as an ongoing provider network participation criteria during the period of approved full credential participation.

g. Medical Suspension/Termination Rights

Information from the Medicaid Suspension/Termination Report is reviewed to determine if the practitioner applicant has been previously suspended or terminated from Medicaid Programs participation. If the practitioner's name is found in the list, the information will be reported to the Committee for discussion and decision.

8. Notification to Authorities and Practitioner Appeal Rights

a. Range of actions

CAMHD reserves the right to rescind the full credentialing status of any practitioner who does not comply with State Ethics Standards, CAMHD Standards, and State and Federal laws.

b. CAMHD shall report serious quality deficiencies that could result in a practitioner's suspension or termination to appropriate authorities.

Upon discovery of any misrepresentation of credentials or other illegal activities will be discussed in the Committee meeting and results of the discussion may warrant reporting, the practitioner's name and situation will be referred to the CAMHD Compliance Committee for investigation, with a copy to the Provider Relations Specialist. If warranted, the practitioner's name may be referred to the designated Medicaid Investigator. CAMHD reserves the right to retain or terminate any practitioner who has misrepresented his/her credentials in any way that compromises services to the CAMHD consumers.

The CAMHD Fraud and Abuse Program outlines CAMHD's procedure for reporting serious quality deficiencies that could result in a practitioner's suspension or termination to the Medicaid Fraud Investigator as well as other appropriate authorities.

c. CAMHD has an appeals process for instances in which it chooses to alter the conditions of the practitioner's participation based on issues of quality of care and/or service.

The following process applies for at any time the applicant disagrees with the Committee decision. This process is included in all *decision letters*.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	20 of 21

9. Interagency Transfer of Credential Status

Practitioner transfers occurring during active credentialing periods shall require verification of items within timeframes as listed in the “*CAMHD Licensed Provider Interagency Transfer Checklist*” as applicable. **(See Attachment 9)** The Committee has authorized the CAMHD Credentialing Specialist to approve transfers if all criteria are satisfied. The names of the applicants approved to transfer will be reported in the next Committee meeting

10. MIS Registration of Credentialed Practitioner

All approved practitioner credential information are reported on a weekly basis by the CAMHD Credentialing Unit to CAMHD Management Information System (MIS) section to be registered in accordance to the established MIS clinician registration guidelines.

11. Credentialing Reports

a. Medicaid Reports

CAMHD must submit to the Department of Human Services Med-QUEST Division (DHS-MQD) a bi-yearly listing of its provider network. At a minimum, the list must include the name of the practitioner, his/her title, site address, and telephone number.

b. CAMHD Performance Improvement Steering Committee (PISC) Reports

The Committee must submit to PISC for review its performance measures for timeliness, quality, and effectiveness on a monthly basis. A representative from the Committee shall attend the PISC meetings.

ATTACHMENTS:

1. CAMHD Glossary of Credentialing Terms
2. CAMHD Licensed Provider Re-credentialing Checklist, Rev. 7-10-03
3. CAMHD Credentialing Committee Member Confidentiality Statement; Version July 2003
4. CAMHD Licensed Provider Re-credentialing Application Form, Rev. 7-11-03
5. CAMHD Attestation Form
6. CAMHD Child Abuse and Neglect Request Form, Rev. 7-11-03
7. CAMHD Child Abuse and Neglect Authorization Form, Rev. 7-11-03
8. CAMHD Child Abuse and Neglect Negative Findings Generic Letter Format

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Re-credentialing of Licensed Health Care Professionals	Number:	80.308.1
	Page:	21 of 21

9. CAMHD Treatment Office Visit Tool; Rev. 7-10-03
10. CAMHD Licensed Provider Interagency Transfer Checklist; Rev. 7-10-03

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	1 of 13
REFERENCE: Child and Adolescent Mental Health Division Quality Assurance Improvement Plan (QAIP)	APPROVED:	
	<i>Signature on File</i>	15 Jul 03
	Chief	Eff. Date

PURPOSE

To assure competent, safe, and effective practices of unlicensed mental health professionals (MHP) and paraprofessionals serving Child and Adolescent Mental Health Division (CAMHD's) consumers.

DEFINITIONS

See Glossary of Credentialing Terms (**Attachment 1**)

POLICY

I. Background Verification and Re-verification Policies

A. Applicant Credentialing Guidelines

Any unlicensed MHP or paraprofessionals who is employed with CAMHD, or is employed or subcontracted by any CAMHD Contracted Provider Agencies (Agency) providing mental health services to CAMHD consumers is covered under this policy.

B. Policies and Procedures

1. CAMHD shall used the following processes to making background verification and re-verification decisions.
2. The CAMHD Credentialing Committee (Committee) shall evaluate the background verification and re-verification of each applicant against the pre-determined criteria listed in the "*CAMHD MHP & Paraprofessional Initial Background Verification Checklist*" and the "*CAMHD MHP and Paraprofessional Background Re-Verification Checklist*" shall facilitate auditing of primary source verifications in the applicant's background verification and re-verification chart. (**See Attachments 2 and 3**)
3. The Committee members shall use their professional and personal knowledge of the applicant's business practices, ethics, and ability to provide quality services to CAMHD consumers in a safe treatment environment in the decision making process. This policy outlines the criteria used to approve applicants.
4. Non-Discrimination

The Committee does not make background verification and re-verification decisions based solely on the applicant's race, ethnic/national identity,

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	2 of 13

gender, age, sexual orientation, or the types of procedures or types of patients the applicant (e.g., Medicaid) specializes in.

5. The CAMHD or its Agency shall notify the applicant of any information obtained during the background verification and re-verification process that varies substantially from the information provided to CAMHD and or the Agency by the applicant.

The applicant must respond within fifteen (15) business days from the date of the notification letter with a *letter of explanation* for the varying information. Additional documents may be submitted to CAMHD and or its Agency to substantiate or explain the variations. CAMHD must respond within fifteen (15) business days from the date of receipt of the *letter of explanation* to review documents and render a decision. The *decision letter* includes the *reconsideration and appeal process* stated below.

6. The Request for Reconsideration & Appeal Process
 - a. If the applicant does not agree with the Committee's decision, he/she has the right to request for reconsideration. Reconsideration requests must be submitted to CAMHD with additional documentation to support the request within fifteen (15) business days from the *decision letter*, unless otherwise stated.
 - b. The Committee will review the submitted documents and issue a *reconsideration decision letter* to the applicant or through the Agency via facsimile or mail within fifteen (15) business days from the date of receipt of the reconsideration request.
 - c. The applicant, either directly or through the CAMHD Agency, has the option to file a formal complaint with CAMHD's Grievance Office (GO) at 733-8495 in the event the Committee holds to its original decision.
7. The process to ensure that applicants are notified of the background verification and re-verification decision within sixty (60) calendar days of the committee's decision.
 - a. A Committee letter is sent to the applicant through the CAMHD Agency within fifteen (15) business days of the decision.
 - b. If the applicant does not agree with the decision they are entitled to request for reconsideration through the "*Request for Reconsideration & Appeal Process*" outlined above.
8. The medical director or other designated health care professional's direct responsibility and participation in the CAMHD credentialing program:

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	3 of 13

- a. The Committee Chairman, a Medical Director from one of CAMHD's Family Guidance Centers, has direct oversight of the CAMHD Credentialing program. His primary role is to ensure that the committee functions within its defined role, evaluates its projected goals through committee approved performance measures, as well as report the committee's activities and accomplishments to the CAMHD Performance Improvement Steering Committee.
 - b. The CAMHD Medical Director sits in the Committee as an ex-officio member to provide guidance and feedback to the committee.
9. The process used to ensure confidentiality of all information obtained in the background verification and re-verification process, except otherwise provided by law.
 - a. The Committee and CAMHD Agencies' Credentialing Specialists and other personnel that have access to background verification information must sign the "*CAMHD Credentialing Committee Member Confidentiality Form*" to ensure confidentiality of all information gathered during the background verification process, except otherwise provided by law, and are used for the sole purpose of background verification. **(See Attachment 4)**
 - b. In addition, any discussions held during the Committee must remain confidential except when otherwise provided by law.
10. The process to delegate background verification and re-verification.

The primary source verification portion of the background verification process is delegated to the CAMHD Contracted Provider Agencies for their employees and subcontractors. This function is delegated to a contracted credentialing verification service for CAMHD employees and contractors. Refer to the "*CAMHD Credentialing Delegation Policies and Procedures*" for specific delegated activities and CAMHD monitoring of those activities.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	4 of 13

C. Applicant Rights

1. The applicant has the right to review submitted information in support of their background verification and re-verification applications. The following statement is included in the “*MHP and Paraprofessional Initial Background Verification Application Form*” and the “*MHP and Paraprofessional Background Re-verification Application Form*” (See **Attachments 5 and 6**) to notify them of this right:

The applicant has the right to request and review primary source verifications obtained on their behalf. A written request must be sent to the CAMHD Credentialing Specialist, CAMHD Credentialing Department, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816.

- a. The CAMHD Credentialing Department shall forward copies of primary source documents to the applicant via regular mail within thirty (30) days of the receipt of the written request from the applicant.
 - b. In the event that the primary source verification function has been delegated to the CAMHD Agency, the written request must be sent to the attention of the Agency Credentialing Specialist. The Agency Credentialing Specialist has thirty (30) days to forward the copies of the primary source documents to the applicant via regular mail.
2. The applicant has the right to correct erroneous information.
 - a. Should the background verification or re-verification information obtained from other sources vary substantially from that provided by the applicant, CAMHD must notify the applicant either directly in writing or through the Agency Credentialing Specialist within fifteen (15) business days from the date of discovery of the discrepancy.
 - b. The applicant has the right to correct erroneous information by submitting a *letter of explanation* including any additional supporting documents to substantiate or explain the erroneous information directly to the CAMHD Credentialing Committee at the following address: *CAMHD Credentialing Specialist, CAMHD Credentialing Department, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816* or through the Agency within fifteen (15) business days from date of receipt of the *notification letter* from CAMHD.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	5 of 13

- c. CAMHD shall review the documents and render a decision no later than thirty (30) days from the date of receipt of the *letter of explanation*. The *decision letter* shall include the appeal process stated in the “*Request for Reconsideration & Appeal Process*” section of this policy.
3. The applicant has the right to request, in writing or through telephone, the status of their background verification and re-verification application.
 - a. CAMHD must respond to such inquiry within 10 business days either in writing or through telephone.
 - b. Applicants may not review peer-review protected information, references, and letters or recommendations.
4. Notification of applicant’s rights.

The applicants are notified of their rights through the background verification application form as well as in the background re-verification application form.

II. Credentialing Committee

A. The Credentialing Committee

1. The standing Child and Adolescent Mental Health Division (CAMHD) Credentialing Committee is designated to provide oversight over CAMHD’s credentialing processes.
2. The committee consists of the following standing members: A Clinical Director from one of the Family Guidance Centers who serves as the chair, the CAMHD Medical Director (ex-officio), the CAMHD credentialing Specialist (ex-officio), a Clinical Psychologist from the Clinical Services Office, another Psychologist from one of the Family Guidance Centers, a Psychiatrist from one of the Family Guidance Center, a Social Worker from the Performance Management Section, the Quality Operations Supervisor who is a Registered Professional Nurse and serves as co-chair, the Child Abuse & Neglect Screening Reviewer, and the Provider Relations Specialist.

B. Credentialing Committee Decisions

1. The Committee has granted the authority to the CAMHD Credentialing Specialist to conduct a preliminary review of each applicant’s credentials in accordance with the “*MHP and Paraprofessional Initial Background Verification Checklist*” and the “*MHP and Paraprofessional Background Re-verification Checklist*” to ensure all primary source verifications being submitted meet CAMHD’s established criteria. Files that meet established

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	6 of 13

criteria are available at the CAMHD Credentialing Unit for the Committee members to review prior to the scheduled meetings. A list of the names of all these applicants who meet the established criteria is presented at the next credentialing committee meeting.

2. Applicants may not provide care to consumers until the final decision is made by the Committee.
3. CAMHD reserves the right to make the final determination about which applicants may participate in its network. If unfavorable information is obtained for an applicant during the credentialing process, CAMHD reserves the right to ask for additional information and render a decision to approve the applicant with or without restrictions or disapprove the applicant. The Committee's *decision letter* includes the reconsideration and appeal process as stated in the "*Request for Reconsideration & Appeal Process*" section of this policy.
4. The reasons for those providers that did not meet the criteria will be discussed during the committee meeting. The applicant will be notified either directly or through the Agency of the deficiencies and corrective action requested through regular or electronic mail. The response deadline will be included in the notification.
5. The Committee has CAMHD has thirty (30) days from the date of receipt of the letter of explanation to review documents and render a decision. The *decision letter* includes the reconsideration and appeal process stated in the "*Request for Reconsideration & Appeal Process*" section of this policy.

III. Initial Background Verification and Background Re-Verification Requirements

A. Method of Verification

1. CAMHD or its Contracted Provider Agencies may use oral, written, and Internet website data to verify information. Oral verifications require a note stating the date of verification, the name of the person from the primary source who verified the information, the name and dated signature of the CAMHD or Agency staff that verified the information.
2. Internet website verification requires the dated signature of the CAMHD or Agency staff that conducted the query on all printed pages. Written verifications may take the form of a letter that is received via regular mail or facsimile.

B. Verification Time Limit

1. To prevent the Committee from considering a provider whose credentials may have changed since they were verified, primary source verification

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	7 of 13

should be no more than 180 days old (unless otherwise stated) at the time of the credentialing committee decision. For written verifications, the 180-daytime limit begins with the date that the credentials were verified (the date on the letter or the signature date) not when CAMHD or the CAMHD Agency received the information.

C. Background Verification Cycle

1. The two-year credentialing cycle begins with the date of the initial credentialing decision. Providers are considered credentialed after the committee has made its decision. Once providers are background verified, they are able to carry their full credential status for all CAMHD Contracted Provider Agencies. Their background is not required to be recredentialed every time they change employment as long as it occurs within the two year approved timeframe. There are requirements for interagency transfer. Refer to the Interagency Transfer section of this policy for those requirements.

D. Applicant Termination and Reinstatement

1. If a CAMHD or CAMHD Agency employee or subcontractor is voluntary or involuntarily terminated and the applicant wishes to be reinstated, the applicant must again be initially credentialed if the break in service is thirty (30) days or more. CAMHD and/or the CAMHD Agency must re-verify background verification factors that are no longer within the required time limits. The Committee must review all documents and makes a final determination prior to the applicant's re-entry into the organization.
2. An interagency transfer is allowed after termination provided it is within thirty (30) days of the termination date and there are no negative incidents that led to the termination from the previous CAMHD Agency. The Committee must review presented facts and makes a final determination prior to the applicant's re-entry into the organization.

E. CAMHD Network Participation Requirements

To be eligible to become a member of the CAMHD network provider, the applicant must be an employee or direct contractor of CAMHD or an employee or subcontractor of a CAMHD Contracted Provider Agencies.

F. Initial Background Verification and Background Re-verification Document Requirements

1. The "*MHP and Paraprofessional Initial Background Verification Checklist*" and the "*MHP and Paraprofessional Background Re-verification Checklist*" outlines the CAMHD required primary source

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	8 of 13

verifications, verification timeline requirements, and methods of accepted primary source verification including the following criteria items:

2. Attestation Letter

Verification time limit: 180 days

The CAMHD Agency or CAMHD designated primary source verification agency representative must complete the “***CAMHD Attestation Letter***”.
(See Attachment 7)

3. Background Verification and Re-verification application Form

Verification time limit: 180 days

a. All sections of the “*MHP and Paraprofessional Initial Background Verification Form*” and the “*MHP and Paraprofessional Background Re-verification Form*” must be completed. The application form must include the following items:

4. Reasons for inability to perform the essential functions of the position, with or without accommodation.

a. *Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.*

b. CAMHD and its Agency must ensure that the following question in the credentialing application form contains a “No” answer.

c. *Do you have any physical and/or mental condition which would interfere with the performance of those privileges which you are requesting and/or the essential functions of the contractual arrangement for which you are applying, with or without accommodation?*

d. In the event an applicant answers “Yes” a letter of explanation must accompany the application. The Committee must review the letter of explanation and weigh the implications of any health conditions stated as it pertains to the applicant’s ability to perform the functions of the position that the provider is being credentialed for. The Committee may consider approval of the applicant with or without restrictions.

5. Lack of present illegal drug use.

a. *Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.*

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	9 of 13

- b. CAMHD and its Agency must ensure that the restrictive actions questions pertaining to illegal drug use in the credentialing application form contains a “No” answer.
 - c. In the event an applicant answers “Yes” a letter of explanation must accompany the application. The Committee must review the letter of explanation and weigh the implications of any illegal drug use reported as it pertains to the applicant’s ability to perform the functions of the position that the provider is being credentialed for.
 6. History of loss of license and felony convictions.
 - a. *Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.*
 - b. CAMHD and its Agency must ensure that the restrictive actions questions pertaining to loss of license and felony convictions in the credentialing application form contains a “No” answer. In addition, the Hawaii Justice Center Check results would also be considered to satisfy the felony conviction verification requirements of this criterion.
 - c. In the event an applicant answers “Yes” a letter of explanation must accompany the application. The Committee must review the letter of explanation and weigh the implications of any loss of license and or felony convictions it relates to the applicant’s ability to perform the functions of the position that the provider is being credentialed for.
 7. History of loss or limitation of privileges or disciplinary activity.
 - a. *Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.*
 - b. CAMHD and its Agency must ensure that the restrictive actions questions pertaining to limitation of privileges or disciplinary actions in the credentialing application form contains a “No” answer
 - c. In the event an applicant answers “Yes” a letter of explanation from the applicant must accompany the application. The Committee must review the letter of explanation and weigh the implications of any loss or limitation of privileges or disciplinary activity it relates to the applicant’s ability to perform the functions of the position that the provider is being credentialed for. The committee reserves the right to ask for a letter from the applicant’s supervisor and or agency to ensure that proper mechanisms are in

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	10 of 13

place to prevent a similar situation from occurring while applicant is around consumers.

8. Attestation as to the correctness and completeness of the application.
 - a. *Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.*
 - b. The applicant must sign and date the following attestation statement in the application:
 - c. *“I represent that information provided in or attached to this credentialing application form is accurate. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in the denial of appointment and clinical privileges. In the event of my termination for this reason, I will not be entitled to any hearing, appeal, or other due process rights. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the <NAME OF AGENCY> may immediately terminate my appointment.”*
9. Education
 - a. *Verification time limit: None. This means that old verifications would be considered acceptable provided it verifies the education that is applicable to the level of education the applicant is being credentialed for.*
 - b. CAMHD or the CAMHD Agency must verify only the highest level of education.
 - c. Confirmation from the university specifically stating name of applicant, degree and date conferred. Written verifications must be received directly from the university attended. Telephone verifications are acceptable provided the name of the person verifying the information; the date of verification, and the person’s name at the primary source is identified in a memo.
 - d. At the time of re-verification, conduct education query only if a higher education was obtained since last verified.
10. Hawaii Justice Center Data Bank Verification:
 - a. The Hawaii Justice Center Data Bank must be queried for any criminal record. The query results must indicate “no records found”. In the event that a record is found, the applicant must provide CAMHD a written

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	11 of 13

explanation of the record. Rehabilitative or self-improvement programs attended to help improve whatever issues there may be at the time of offense shall be listed. In addition, the CAMHD Agency must also submit to CAMHD a written supervision plan that outlines the position and overall function of the applicant, supervision structure, and any other mechanisms in place to prevent similar offenses from occurring while the applicant is employed with the CAMHD Agency or around CAMHD consumers.

11. Child and Abuse Neglect Verification.

- a. *Verification time limit: 180 days*
- b. The Department of Human Services Child Protective Services Database would be queried for child abuse and neglect records. The “*CAMHD CAN Request Form*” and “*CAMHD CAN Authorization Form*” must be completed. **(See Attachment 8 and 9)**. The query results must indicate “*no records found*”. In the event that a record is found, CAMHD must notify the applicant or the CAMHD Agency of the record. Please refer to the “*CAMHD CAN Negative Result Generic Letter*”. **(See Attachment 10)**

G. Initial and Subsequent Background Verification Site Visits

1. Onsite visits are not required for background verification of MHPs and paraprofessionals since they are supervised by licensed mental health professionals.

H. Ongoing Monitoring of Sanctions and Complaints

1. Grievance Office

- a. Information from the CAMHD Grievance Office regarding a specific provider is reported to the credentialing department of the complaint. A brief synopsis of the complaint is included in the notification. The Performance Management Section will conduct an investigation and report their findings to the Committee. The Committee will review the recommendations and make its final determination whether to suspend or permanently terminate the applicant’s credentialing status.

2. Sentinel Events Office

- a. Information from the CAMHD Sentinel Events Office regarding specific provider is reported to the credentialing department. The nature of the event is included in the notification. The Performance Management Section will conduct an investigation and report their findings to the Committee. The Committee will review the

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	12 of 13

recommendations and make its final determination whether to
suspend or permanently terminate the applicant's credentialing
status.

I. Notification to Authorities and Applicant Appeal Rights

1. Range of actions

- a. CAMHD reserves the right to rescind the full credentialing status of any applicant that does not comply with State Ethics Standards, CAMHD standards, and State and Federal laws.

2. Reporting of serious quality deficiencies that could result in an applicant's suspension or termination to appropriate authorities.

- a. Upon discovery of any misrepresentation of credentials or other illegal activities will be discussed in the Committee meeting and results of the discussion may warrant reporting the clinician's name and situation will be referred to the CAMHD Compliance Committee for investigation, with a copy to the Provider Relations Specialist. If warranted, licensed clinician's name may be referred to the designated Medicaid Investigator. CAMHD reserves the right to retain or terminate any clinician that has misrepresented his or her credentials in any way that compromises services to the consumers.
- b. The CAMHD Fraud and Abuse Program outlines CAMHD's procedure for reporting serious quality deficiencies that could result in a provider's suspension or termination to the Medicaid Fraud Investigator as well as other appropriate authorities.

3. CAMHD has an appeals process for instances in which it chooses to alter the conditions of the applicant's participation based on issues of quality of care and/or service.

IV. Interagency Transfer of Credential Status

- A. Clinician transfers occurring during active credentialing periods shall require verification of items within timeframes as listed in the "*CAMHD Unlicensed Provider Interagency Transfer Checklist*" as applicable. **(See Attachment 11).** The Committee has authorized the CAMHD Credentialing Specialist to approve transfers if all criteria are satisfied. The names of the providers approved to transfer will be reported in the next Committee meeting

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Initial Background Verification and Re-verification of Unlicensed Mental Health Professional and Paraprofessionals	Number:	80.308.2
	Page:	13 of 13

V. CAMHD Management Information System (MIS) Registration of Credentialed Applicant

The CAMHD Credentialing Unit shall report all approved applicant credential information on a weekly basis to the MIS to be registered in accordance to the established MIS clinician registration guidelines.

VI. Credentialing Reports

A. Medicaid Reports

CAMHD must submit to the Department of Human Services Med-QUEST Division (DHS-MQD) a bi-yearly listing of its provider network. At a minimum, the list must include the name of the provider, their highest education obtained, site address, and telephone number.

B. CAMHD Performance Improvement Steering Committee (PISC) Reports

The Committee must submit to PISC for review its performance measures for timeliness, quality, and effectiveness on a monthly basis. A representative from the Committee shall attend the PISC meetings.

ATTACHMENTS:

1. Glossary of Credentialing Terms
2. CAMHD MHP and Paraprofessional Initial Background Verification Checklist, Rev. 7-10-03
3. CAMHD MHP and Paraprofessional Background Re-verification Checklist, Rev. 7-10-03
4. CAMHD Credentialing Committee Member Confidentiality Form; Version July 2003
5. CAMHD MHP and Paraprofessional Initial Background Verification Form, Rev. 7-11-03
6. CAMHD MHP and Paraprofessional Background Re-verification Form, Rev. 7-11-03
7. CAMHD Attestation Letter
8. CAMHD Child Abuse and Neglect Request Form, Rev. 7-11-03
9. CAMHD Child Abuse and Neglect Authorization Form
10. CAMHD Child Abuse and Neglect Negative Findings Generic Letter Format
11. CAMHD MHP and Paraprofessional Interagency Transfer Checklist; Rev. 7-10-03

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.308.3

CAMHD Administration

Page 1 of 7

SUBJECT: Delegation of Credentialing Primary Source Verification

REFERENCE: CAMHD Credentialing Policies and Procedures for Licensed and Unlicensed Providers; NCQA, BBA

APPROVED: Eff. Date
Signature on File 15 Jul 03

Chief

PURPOSE

To provide guidelines and timelines for the delegation of credentialing activities by CAMHD to CAMHD contracted provider agencies (Agency/ies) providing mental health services. The policy also provides guidelines for monitoring the delegated activities of the CAMHD Agencies.

DEFINITIONS

See Glossary (**Attachment 1**)

POLICY

The CAMHD is responsible and will be held accountable to ensure that all delegated credentialing functions and activities are performed in accordance with the specifications outlined in this policy.

The CAMHD shall evaluate a prospective delegate's ability to provide the intended delegated credentialing functions.

The CAMHD shall review and approve all descriptions of delegated credentialing activities prior to the approval of a delegation agreement.

The CAMHD shall monitor delegated activities regularly using the formal, systematic processes outlined within this policy to assess the delegate's compliance.

PROCEDURE

PRE-DELEGATION ASSESSMENT

1. Prior to the delegation of credentialing activities and functions the CAMHD will pre-assess an Agency or credentials verification service contractor to determine its ability to perform the activities and functions as outlined in the "CAMHD Pre-Delegation Assessment Tool." (**See Attachment 2**)
2. The results of the pre-assessment audit will be reported to the CAMHD Credentialing Committee for review and decision.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.308.3

CAMHD Administration

Page 2 of 7

RESPONSIBILITIES AND ACCOUNTABILITY OF THE DELEGATE

1. Initial Credentialing:

- A. The CAMHD Agency or credentials verification service contractor shall obtain initial credentialing primary source verifications using methodology and times frames as outlined in the “*CAMHD Licensed Provider Initial Credentialing Checklist*” (See Attachment 3), the “*CAMHD MHP and Paraprofessional Initial Background Verification Checklist*” (See Attachment 4)
- B. The CAMHD Agency will obtain credentialing and background verification approval for all practitioner (licensed or unlicensed) from CAMHD *prior* to serving CAMHD consumers. ***Services provided prior to this CAMHD approval will not be reimbursed.***
- C. The CAMHD Agency credentialing specialist or a primary source verification service representative must do the following:
 - 1. Obtain a completed credentialing application form from the practitioner.
 - 2. Create an agency credentialing file for each provider applicant.
 - 3. Obtain necessary consents to conduct credentialing primary source verifications.
 - 4. Conduct primary source verifications as outlined in the “*CAMHD Licensed Provider Initial Credentialing Checklist*” and “*CAMHD MHP and Paraprofessional Initial Background Verification Checklist.*”
 - 5. Conduct a pre-audit of primary source verified documents to ensure they meet CAMHD requirements – using the “*CAMHD Licensed Provider Initial Credentialing Checklist*” and the “*CAMHD MHP and Paraprofessional Initial Background Verification Checklist*” as guides.
 - 6. Maintain the original primary source verification documents in the practitioner’s file at the CAMHD Agency. Existence of the originals will be verified during on-site audit visits.
 - 7. Create a duplicate credentialing file for the applicant with all the primary source verification.
 - 8. Tab primary source verifications with numbers to match the numbers on the “*Licensed Provider Initial Credentialing Checklist and the MHP and Paraprofessional Initial Background Verification Checklists.*”
 - 9. Send a duplicate file to the CAMHD Credentialing department.
 - 10. Keep current a file of all documents that have expiration dates such as licenses and malpractice insurance.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.308.3
CAMHD Administration	Page	3 of 7

11. Send copies of updated license verification and malpractice coverage face sheets to the CAMHD Credentialing Department.
2. Re-credentialing:
 - A. The CAMHD Agency will conduct the re-credentialing primary source verifications as outlined in the “*CAMHD Licensed Provider Re-credentialing Checklist*” (See Attachment 5) and the “*CAMHD MHP and Paraprofessional Background Re-verification Checklist*.” (See Attachment 6) The primary source verification requirements must follow primary source verification methodology and time frames as outlined in the “*CAMHD Licensed Provider Re-credentialing Policies and Procedures*” and the “*CAMHD MHP and Paraprofessional Background Re-verification Policies and Procedures*.”
 - B. The CAMHD Agency will obtain re-credentialing and background re-verification approval for all practitioners (licensed or unlicensed) from CAMHD **prior** to expiration of original credentialing dates. ***Services provided in the time period between the end of the original credentialing end date and the start of the re-credentialing period will not be reimbursed.***
 - C. The CAMHD Agency credentialing specialist or a primary source verification service representative must do the following:
 1. Obtain a completed credentialing re-application or background re-verification form from the practitioner.
 2. Obtain necessary consents to conduct re-credentialing or background re-verification primary source verifications.
 3. Obtain primary source as outlined in the “*CAMHD Licensed Provider Initial Re-credentialing Checklist*” and the “*CAMHD MHP and Paraprofessional Background Re-verification Checklist*.”
 4. Conduct a pre-audit of obtained primary source documents to ensure they meet CAMHD requirements – use the “*CAMHD Licensed Provider Re-credentialing Checklist*” and the “*CAMHD MHP and Paraprofessional Background Re-verification Checklist*” as guides.
 5. Maintain original primary source re-verifications in the clinician file at the CAMHD Agency. Existence of the originals will be verified during onsite audit visits.
 6. Create a duplicate file for the applicant with all the primary source re-verifications.
 7. Tab primary source re-verifications with numbers to match the numbers on the “*CAMHD Licensed Provider Re-credentialing Checklist*” and the

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.308.3

CAMHD Administration

Page 4 of 7

“CAMHD MHP and Paraprofessional Background Re-verification Checklist”.

8. Send a duplicate file to the CAMHD Credentialing Department.
9. Keep current in the file all documents that expire such as licenses and malpractice insurance.
10. Send copies of updated license verification and malpractice coverage face sheets to the CAMHD Credentialing Department.

3. Monthly Credentialing Reports

The CAMHD Agency will provide CAMHD with a credentialing monthly report in the format prescribed by CAMHD. The CAMHD Agency Monthly Report identifies the required information for this report. This report must include:

1. All current employees and subcontractors that provide direct services.
2. All currently employees and subcontractors that supervise direct service clinicians.
3. Terminations for the current month and termination reason code as stated in the “Termination Code Listing.” **(See Attachment 7)**
4. Submit the report to CAMHD by the 15th of the month being reported.

4. Operational Requirements:

- A. The CAMHD Agency shall ensure that the CAMHD requirements as outlined in the *“CAMHD Contracted Agency Credentialing Systems Audit Tool”* are in place. **(Attachment 8)**
- B. The CAMHD Agency shall have documented processes in place to monitor the activities of their credentialing department. The supervisor for their credentialing specialist must have knowledge of the current CAMHD credentialing requirements in order for them to efficiently implement them and monitor the performance of their staff.

5. Delegate’s Accountability to CAMHD

The delegate is accountable to ensure that all activities set forth in this delegation policy and procedures are completed in accordance to CAMHD requirements within the specified timelines.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.308.3

CAMHD Administration

Page 5 of 7

TIMEFRAME OF DELEGATED ACTIVITIES

The delegated activities and functions described in this policy will be effective as of the date of signature of the CAMHD delegation agreement with the delegate.

MONITORING OF DELEGATED ACTIVITIES

1. Schedule and Location:

On-site monitoring of delegated activities and credentialing operations/systems will be conducted at least annually at the CAMHD Agency office where the credentialing files are kept. CAMHD has the right to conduct additional on-site visits as indicated by program quality issues that may arise.

2. Tools and Thresholds:

- A. The sample agency credential files will be audited using the “Licensed Provider CAMHD Contracted Agency Credential File Audit Form” (**Attachment 9**) or the “MHP and Paraprofessional CAMHD Contracted Agency Credential File Audit Form.” (**Attachment 10**) The date of primary source verifications that were originally submitted to CAMHD for review will be pre-listed on these tools.
- B. The CAMHD Agency must provide original documents for the audit. Absent original documents will be noted as such if they cannot be found by the conclusion of the on-site audit. The CAMHD Agency must complete, at a minimum, 85% of the requirement listed in the tool to demonstrate substantial compliance with this activity.
- C. The “*CAMHD Contracted Agency Credentialing Systems Audit*” tool will be used to evaluate other delegated credentialing functions and requirements. The threshold score of 85% is required to demonstrate substantial compliance. (**See Attachment 11**)

3. Sample Size:

- A. CAMHD will provide the CAMHD Agency with the sample for the agency credential files audit no later than 2 days before the audit.
- B. The sample size will be at least 25% or 20 files, whichever is lesser, for each category (licensed and unlicensed) of the clinician files inclusive of all psychiatrists.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.308.3

CAMHD Administration

Page 6 of 7

REPORTING OF ONSITE AUDIT FINDINGS AND CORRECTIVE ACTION REQUESTS AND RESPONSES

1. Reporting of Findings to the Delegate

- A. At the close of the visit the CAMHD auditor will conduct an exit interview with the CAMHD Agency credentialing specialist and any other pertinent personnel. The CAMHD auditor will go over findings and items that would be requested in a corrective action plan, if any.
- B. The written report for the on-site audit will be sent to the CAMHD Agency Administrator and Credentialing Specialist no later than 30 days after the audit date stating specific corrective action activities and timelines for completion.

2. Reporting of Findings to the CAMHD Credentialing Committee

- A. A draft copy of the written report of the onsite audit results will be presented to the CAMHD Credentialing Committee at the meeting following the completion of the onsite visit. The Credentialing Committee will review the results and make recommendations that will be included in the final corrective action report sent to the CAMHD Agency.
- B. The CAMHD Credentialing Committee will report these findings to request the CAMHD Performance Improvement Steering Committee for review and recommended actions as applicable.

3. Corrective Action Activities

The CAMHD Agency' corrective action plans and any supporting documents must be submitted to the CAMHD Credentialing Specialist no later than 30 days from the CAMHD Agency's receipt of the onsite audit report. CAMHD shall respond as appropriate.

4. Follow-up On-site Visit

CAMHD reserves the right to conduct a follow up on-site visit to ensure corrective activities stated in the corrective action plan are in fact being implemented by the agency, with a one-week notice prior to the visit provided to the agency.

SUSPENSION OR REVOCATION OF DELEGATION

CAMHD retains the authority to suspend or revoke delegated activities upon the CAMHD Agency's continued inability to implement corrective action activities resulting in a score lower than the established threshold of 85% in any of the evaluated sections after the third on-site visit or at any time the delegate fails to fulfill its delegated obligations.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.308.3

CAMHD Administration

Page 7 of 7

RESPONSIBILITIES OF CAMHD

- A. CAMHD will review submitted files and either approve or disapprove the files within thirty (30) working days of receipt of file.
- B. In the event that a file is not approved, CAMHD will notify the CAMHD Agency via telephone or electronic mail of the deficiencies. The agency will be advised that the file will be kept in the CAMHD Credentialing office for thirty (30) days.
- C. Files that are not presented to the CAMHD Credentialing Committee after thirty (30) days of deficiency notification will be returned to the CAMHD Agency.
- D. CAMHD retains the authority to conduct monitoring reviews as described above to ensure that delegated credentialing functions and operational systems are being performed in accordance to CAMHD standards and expectations.
- E. CAMHD retains the right to suspend or revoke delegated activities as described the in the “Suspension or Revocation” section of this policy.

ATTACHMENTS:

- 1. Glossary of Credentialing Terms
- 2. CAMHD Pre-Delegation Assessment Tool, Version: 7/14/03
- 3. CAMHD Licensed Provider Initial Credentialing Checklist, Revised: 7/10/03
- 4. CAMHD MHP and Paraprofessional Initial Background Verification Checklist, Version: 7/10/03
- 5. CAMHD Licensed Provider Recredentialing Checklist, Revised: 7/10/03
- 6. CAMHD MHP and Paraprofessional Background Re-Verification Checklist, Revised: 7/10/03
- 7. Termination Code List, Hawaii Prepaid Medical Management Information System Health Plan Manual (Hawaii PMMIS) Provider Status Codes (PMR only), Version 2.0
- 8. CAMHD Contracted Agency Credentialing Systems Audit. Version: 7/10/03
- 9. CAMHD Contracted Agency Licensed Providers Credential File Audit Form, Version: 7/10/03
- 10. CAMHD Contract Agency MHP and Paraprofessional Credential File Audit Form, Version: 7/10/03
- 11. Delegate Evaluation Scoring Compliance Scale

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.402
CAMHD Administration	Effective Date: April 3, 2003 History: 12/16/02
SUBJECT: Confidentiality, FAX Transmissions	Page: 1 of 4
REFERENCE: HRS 334-5, Confidentiality of Records; CARF Organizational Standards for Information Management; 45 C.F.R. 164.530; 34 C.F.R. Part 99 (FERPA)	APPROVED: <i>Signature on File</i>
	Chief

PURPOSE

To establish reasonable safeguards to protect the privacy of protected health information transmitted by FAX.

DEFINITION

Health Information - any information, whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; or the past, present, or future payment for the provision of health care to the individual.

“Individually Identifiable Health Information” – information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - a) That identifies the individual; or
 - b) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.402

CAMHD Administration

Page 2 of 4

Protected Health Information –individually identifiable health information that is transmitted by electronic media or maintained in electronic form/medium that is:

1. Transmitted by electronic media;
2. Maintained in any medium described in the definition of electronic media at 45 CFR §162.103 of this subchapter; or.
3. Transmitted or maintained in any other form or medium.

Protected health information excludes individually identifiable health information in:

- a) Education records covered by the Family Educational Rights and Privacy Act (FERPA) as amended by 20 U.S.C. 1232g;
- b) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
- c) Employment records held by a covered entity in its role as employer.

Secured Location - area where the fax machine is located that is accessible only by the recipient or person(s) within the program for which the transmission is intended.

POLICY

The risks and benefits of faxing information about consumers should be weighed carefully before FAX technology is used. All requirements for release and disclosure of protected health information, as identified in the CAMHD P&Ps and as required by federal and state laws, shall be met prior to faxing consumer information. Appropriate staff who are authorized shall fax protected health information.

PROCEDURE

- A. All FAX transmissions containing protected health information about consumers shall have a cover sheet which includes at least:
 1. The name of the person or designee to which the information is being sent (recipient);
 2. The number to which the information is to be sent;
 3. The person responsible for the transmission (sender);
 4. The phone number from which the transmission was sent;
 5. A description of the material(s) sent, excluding protected health information; and

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.402

CAMHD Administration

Page 3 of 4

6. The following statement:

THIS COMMUNICATION IS INTENDED ONLY FOR THE USE OF THE PERSON OR PROGRAM NAMED ABOVE, AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL, AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. WE AUTHORIZE DISCLOSURE OF THIS COMMUNICATION TO SUCH PERSON OR PROGRAM ONLY. IF YOU HAVE RECEIVED THIS INFORMATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY (BY COLLECT CALL, AND RETURN THIS ORIGINAL COMMUNICATION TO US AT OUR ABOVE ADDRESS VIA U.S. POSTAL SERVICE. THANK YOU.

- B. When faxing to a secured location:

1. The sender must verify with a credible source the fax number of the intended destination.
2. The number entered into the fax machine shall be checked for accuracy against the number on the cover sheet.
3. The sender shall confirm the transmission and verify that the recipient's number matches the number of the intended destination indicated on the confirmation sheet. If using a fax machine that does not produce confirmation of transmission the sender must follow the procedure for sending a fax to a location that is not secured.

- C. When faxing to a location that is not secured and prior to starting the transmission:

1. The sender shall call ahead to the intended fax destination to inform the recipient that the fax is being sent and request that the recipient receive the fax or deliver to the person identified on the fax cover sheet.
2. The sender shall request that the recipient confirm upon receipt that the fax was received.
3. If a recipient is not available at the intended destination when the call is placed, the sender shall wait to fax the report until a recipient is available to receive the transmission.

- D. The transmission sheet or the cover sheet shall be placed in a central administrative file as confirmation of the transmission.

- E. In the event that protected health information is faxed to the wrong number, and no communication to this effect is received from the mistaken location as requested by the statement on the cover sheet, a second fax shall be sent to the wrong number with the statement:

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.402
CAMHD Administration	Page 4 of 4

YOU HAVE RECEIVED A TRANSMISSION FROM US IN ERROR. PLEASE CALL THE NUMBER OF THE PERSON THAT SENT THE TRANSMISSION, IDENTIFIED ON THE ORIGINAL FAX COVER SHEET, TO CONFIRM THIS. PLEASE MAIL THE ORIGINAL FAX BACK TO US AT _____ [Insert the address of Central Office or the involved CAMHD Branch].

ATTACHMENT(S): None

Review Dates: ____/____/____; ____/____/____; ____/____/____; ____/____/____/

Chief's Initials: [_____] [_____] [_____] [_____] [_____]

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.405
CAMHD Administration	Effective Date: February 5, 2003 History: 8/06/95
SUBJECT: Mandatory Reporting of Child Abuse or Neglect	Page: 1 of 3 APPROVED:
REFERENCE: 45 C.F.R. §164.512; 34 C.F.R. Part 99; HRS Chapter 350, Child Protective Services - A Guide for Mandated Reporting, Intra-Departmental Directive No. 88-3	Chief

PURPOSE

To establish guidelines for reporting suspected cases of child abuse or neglect.

DEFINITIONS

"**Child abuse or neglect**" is defined as acts or omissions of any person who, or by legal entity which is in any manner or degree related to the child, is residing with the child, or is otherwise responsible for the child's care, that have resulted in harm to the physical or psychological health or welfare of a person under the age of eighteen or where there is any reasonably foreseeable, substantial risk of such harm. The acts or omissions are indicated for the purposes of reports by circumstances that include but are not limited to:

- A. When the child exhibits evidence of child abuse and/or neglect including, but not limited to substantial or multiple skin bruising or any other internal bleeding, any injury to skin causing substantial bleeding, malnutrition, failure to thrive, burn or burns, poisoning, fracture of any bone, subdural hematoma, soft tissue swelling, extreme pain, extreme mental/emotional distress, gross degradation, death, and injury is not justifiably explained, or when the history given concerning such condition or death is at variance with the degree or type of such condition or death, or circumstances indicate that such condition or death may not be the product of an accidental occurrence; or
- B. When the child has been the victim of sexual contact or conduct, including, but not limited to rape, sodomy, molestation, sexual fondling, incest, or prostitution, obscene or pornographic photographing or filming or depiction, or other similar forms of sexual exploitation; or
- C. When there exists injury to the psychological capacity of a child as is evidenced by an observable and substantial impairment in the child's ability to function; or
- D. When the child is not provided in a timely manner with adequate food, clothing, shelter, or psychological care, physical care, medical care, or supervision; or
- E. When the child is provided with dangerous, harmful, or detrimental drugs as defined by section 712-1230, HRS; provided that this paragraph shall not apply

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.405
CAMHD Administration	Page	2 of 3

when drugs are provided to the child pursuant to the direction or prescription of a practitioner, as defined in section 712-1240, HRS.

POLICY

CAMHD may disclose an individual's protected health information to the appropriate government authority authorized by law to receive reports of child abuse and neglect pursuant to 45 C.F.R. §164.512(b)(1)(ii). CAMHD may also disclose personally identifiable information from an educational record to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student. 34 C.F.R. §99.36(a)

All CAMHD employees, or employees of a contracted agencies, who, in the performance of their professional or official duties, know or have reason to believe that child abuse or neglect has occurred shall promptly report the matter to the Department of Human Services, Public Welfare Division, Child Protective Services.

All students, interns and volunteers, who in the performance of their duties, know or have reason to believe that child abuse or neglect has occurred shall promptly advise their supervisor, and together they shall report the matter to the Department of Human Services, Child Protective Services.

PROCEDURE

1. When any employee or employee of contracted agency, has knowledge of or suspects child abuse or neglect, the employee shall immediately make an oral report to Child Protective Services of the Department of Human Services, requesting an oral response within five (5) working days. The usual vehicle will be the Child Abuse and Neglect (CAN) twenty-four (24) hour hotline on Oahu:

Name and address of child victim and name of parents or other caretaker;

Child's birth date or age;

Names and ages of other persons who live with the child and their relationship to the child, if known;

Nature and extent of the abuse or neglect, including any evidence or indication of previous abuse or neglect;

Date, time and location of incident;

Child's current location and condition;

Identity of alleged perpetrator;

Whereabouts of alleged perpetrator and any history if available;

Any other information that may be helpful in determining the cause of the abuse or neglect; and

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.405
CAMHD Administration	Page	3 of 3

- Whether or not there might be a family member who might be able to protect the child.
2. The employee shall notify his/her immediate supervisor that a report has been made and the supervisor shall notify CAMHD Performance Manager.
 3. The employee shall complete a Child Abuse and Neglect (CAN) Mandatory Reporting Form and submit it to Child Protective Services (CPS) within three (3) working days of the oral report. A copy of the report shall be kept in an administrative file whether or not the consumer is the alleged perpetrator.
 4. Within three (3) working days of the written report, if the CPS worker has not responded, attempts to make telephone contact shall be documented in the consumer's chart. The results of the contact shall be entered at the bottom of the reporting form.

ATTACHMENT(S): Child Abuse and Neglect (CAN) Mandatory Reporting Form

Review Dates: ____/____/____; ____/____/____; ____/____/____; ____/____/____/
Chief's Initials: [_____] [_____] [_____] [_____]

TO: Child Protective Services, Department of Human Services, Social Services Division
FROM: Child and Adolescent Mental Health Division

Child Abuse and Neglect Mandatory Reporting Form
Confidential

Child's Name (Last Name, First Name Middle Name)			Date of Birth (MM/DD/YY)	
Address:				
Telephone Number:		Child's School:		
Name of Parent(s) / Caretaker:				
Address (if different from Child's)				
Reported to:		Date:		Time:
Incident Date:	Time:	Time: Location:		
Nature and extent of the abuse or neglect; include evidence or indication of previous abuse or neglect:				
Child's current location and condition:				
Identify of alleged perpetrator:				
Whereabouts of alleged perpetrator and any available history:				
Other pertinent information:				
Person making report Name (Printed and Signature) Title				
FGC Branch/Section			Phone:	
			Fax:	
Date	Signature			
CPS: Accepted Declined and Reason				
Date of Contact:	CPS Worker:		Phone:	Fax:

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.601
CAMHD Administration	Page 1 of 6
SUBJECT: Consumer Handbook	
REFERENCE: 45 C.F.R. Parts 160 and 164 (HIPAA); 42 C.F.R. 438.10, 42 C.F.R. 438.100 (Medicaid); 34 C.F.R. Part 99 (FERPA); HRS §92F-21, §622-51	APPROVED:
	<i>Signature on File</i> July 21, 2003
	Chief Eff. Date

PURPOSE

To ensure that consumers accessing CAMHD behavioral health services are aware of their rights and responsibilities, and to assure that the consumer's rights are upheld by all CAMHD staff and providers of services.

DEFINITIONS

"Consumer" - Youth with emotional and/or behavioral challenges receiving intensive mental health services from CAMHD. For the purposes of this policy the definition of *"consumer"* shall include the **youth**, parent(s), legal guardian or designated third party representative.

"Enrollee" - Consumers who are enrolled in the CAMHD-Quest behavioral health plan

"Prevalent Non-English Languages" -- means a non-English language spoken by a significant number or percentage of potential consumers and consumers in the State.

POLICY

- A. The CAMHD shall inform all consumers of their rights and responsibilities at the first face-to-face meeting following registration through a review of the Consumer Handbook (Handbook). The CAMHD shall provide each consumer and family a copy of the Handbook (See Attachment A) including alternative formats upon request. The alternative formats are translated versions of the Handbook in Ilocano, Tagalog, Chinese, or Korean, and large print or audio for visually or hearing impaired consumers.
- B. The rights of consumers who receive services from CAMHD shall be addressed in the Handbook using the following terminology:
 1. You have the right to be treated with respect no matter who you are. You also have the right to your privacy.
 2. You have the right to treatment no matter what your situation is. You have this right regardless of your:
 - Age
 - Race
 - Sex

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.601
CAMHD Administration	Page	2 of 6

- Religion
- Culture
- Lifestyle
- Ability to communicate
- Disability

- C. You have the right to know about the CAMHD, the services you can receive and who will provide the services. You also have the right to know what your treatment and service choices are.
3. You have the right to know all your rights and your responsibilities.
 4. You have the right to get help from CAMHD in understanding your services.
 5. You are free to use your rights. Your services will not be changed nor will you be treated differently if you use your rights.
 6. You have the right to receive information and services in a timely way.
 7. You have the right to be a part of all choices about your treatment. You have the right to have your treatment plan in writing.
 8. You have the right to disagree with your treatment or to ask for changes in your treatment plan.
 9. You have the right to ask for a different provider. If you want a different provider, CAMHD will work with you to find another provider in its provider network.
 10. You have the right to refuse treatment.
 11. You have the right to get services in a way that respects your culture and what you believe in.
 12. You have the right to look at your records, and add your opinion when you disagree. You can ask for and get a copy of your records. You have the right to expect that your information will be kept private within the law.
 13. You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.
 14. You have the right to be free from being restrained or secluded unless an allowed doctor or psychologist approves, and then only to protect you or others from harm. They can never be used to punish you or keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.
- D. The Handbook includes the responsibilities of the consumer. The consumer's responsibilities shall be addressed in the Handbook using the following terminology:

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.601
CAMHD Administration	Page	3 of 6
<ol style="list-style-type: none">1. Your responsibility is to make sure you keep your child's scheduled appointments. If you are going to miss an appointment call the person involved as soon as possible. Ask them to make a new appointment with you.2. Your responsibility to answer all questions about your child and family in an honest way. This is important so CAMHD can give good care to the your child.3. Your responsibility is to be a part of your child's assessment and Treatment Plan.4. Your responsibility is to be a part of your child's Coordinated Service Plan.5. Your responsibility is to know what is going on with your child's treatment and do your part. This means doing the work that you are assigned to do as part of helping your child.6. Your responsibility is to treat all people who provide services with respect.		
E. The Handbook shall address the following:		
<ol style="list-style-type: none">1. Written materials that are in easily understood language (sixth grade level) and format2. Consumers are informed that alternate Handbook formats (<i>e.g.</i> audio, large print) are available and how they can obtain the alternate format information3. Information that includes basic features of managed care4. Which populations are excluded from enrollment5. Populations that are subject to mandatory enrollment6. CAMHD responsibilities for coordination of consumer's care7. Summary of service information specific to CAMHD8. Summary of benefits covered9. Information about benefits covered under the CAMHD but are not covered under contracts with providers and information on how to access these services10. Disenrollment rights11. Providing and informing consumers about Oral Interpretation Services and how to access these services as applicable to all non-English languages12. Handbook availability in the following languages: Tagalog, Chinese, Ilocano, and Korean13. A mechanism to help consumers understand the requirements and benefits of their plan, both in writing and via toll-free telephone contact14. Toll-free access availability twenty-four (24) hours a day, seven (7) days a week15. Any restrictions on the consumer's freedom of choice among network providers16. Rights, requirements and timeframes for filing a grievance and/or appeals		

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.601
CAMHD Administration	Page	4 of 6
<ul style="list-style-type: none">17. The availability of assistance with the grievance filing process18. The toll-free number that the consumer may use to initiate a grievance or an appeal, or request information19. Written information on the CAMHD's structure and operation20. The amount, duration and scope of benefits available under CAMHD in sufficient detail to enable the enrollee to understand their benefits21. Procedures for obtaining services, including the requirements for receiving an authorization for services22. The extent to which and how consumers may obtain services from out-of-network providers if applicable23. The extent to which and how after-hours and emergency coverage are provided24. Information on emergency services, telephone numbers and contacts, and what constitutes emergency medical conditions25. The fact that an authorization is not necessary for an emergency service26. Procedures for obtaining emergency services to include use of the 911-telephone system, as applicable27. Information on post-stabilization service rules covered at §422.113(c), as applicable28. Information on how to access the referral system for specialty care and for other benefits not furnished by the consumer's primary provider29. Information on how to access services covered under the State plan but are not covered under the CAMHD contract30. Information on transportation services31. Making an appointment32. Reporting changes in status and family composition33. Reporting of a third party liability34. Information regarding use of the membership card35. Penalties for fraudulent activities36. Out-of-state or off-island medical services37. Confidentiality of member information38. To be treated with dignity and privacy39. Receive information on available treatment options40. Participate in decisions		

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.601
CAMHD Administration	Page	5 of 6

41. To be free from restraint or seclusion
 42. To a copy of their medical records
 43. Freedom to exercise their rights
 44. Rights to refuse treatment
- F. The Handbook shall address the following as applicable to consumers who are identified as Quest enrollees:
1. Information on how to file for a State Fair Hearing
 2. Information on how a physician or other representative can represent them when filing for a grievance, appeal, or State Fair Hearing
 3. Continuation of benefits during an appeal or State Fair Hearing to include: If a recipient requests continuation of benefits during an appeal or State Fair Hearing, they may be required to pay the cost of services furnished while the appeal or hearing is pending, if the final decision is adverse to the recipient
 4. Information that the enrollee, the enrollee's provider, or an appointed representative may file a request for an external review of a managed care plan's final internal determination with the State of Hawaii's Insurance Commissioner
 5. The right to use any hospital in the State for emergency care, as applicable
 6. Information on "significant" changes in the health plan that affect access, timeliness and/or quality of care affecting enrollee's understanding of procedures for receiving care thirty (30) days before the intended effective change
 7. Failure to pay for non-covered services will not result in loss of Medicaid benefits

PROCEDURE

- A. The CAMHD Quality Operations Supervisor (QOS) shall assure the correctness of the Handbook, that it meets all requirements of the Balanced Budget Amendment and is approved by QUEST.
- B. The QOS shall oversee and assure the distribution of the Handbook to all CAMHD Family Guidance Centers (FGC), CAMHD Central Administration for ready availability to consumers at registration and on request. All CAMHD staff have the responsibility to know and uphold the rights and responsibility of consumers listed in the Handbook.
- C. The Handbook shall be placed on the CAMHD website to allow providers and other interested parties ready access to it. The QOS shall ensure that providers include the Handbook in their quality assurance training. All providers have the responsibility to know and uphold the rights and responsibility of consumers listed in the Handbook
- D. All CAMHD FGC Care Coordinators (CC) will receive training from their Quality Assurance Specialist or staff designated by the FGC Branch Chief on the full content of the Handbook including the consumer rights and responsibilities.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.601
CAMHD Administration	Page	6 of 6

- E. The FGC CC shall ensure that all consumers receive a copy of the Handbook and any subsequent editions. At the first face-to-face meeting with the consumer following registration, the CC will review and inform the consumers of their rights and responsibilities. The CC will:
1. Provide consumers with a copy of the rights handbook titled, "Consumer Handbook".
 2. Review and explain the contents of the Handbook and, if necessary, offer to obtain an interpreter to give assistance in the explanation.
 3. Provide responses to any questions the consumer may have about their rights and about the CAMHD program.
 4. Upon completion of the review, have the consumer complete and sign the Consumer Handbook Acknowledgement Form (See Attachment B) indicating the receipt of the Handbook
 5. Place the signed Consumer Handbook Acknowledgement Form in the consumer's chart including the date of review with the consumer and the date of their receipt of the Handbook.
- F. The Handbook will have an edition dated designation on the lower left-hand side of the cover page, *e.g.*, 1st, 2nd, 3rd edition, etc.

ATTACHMENT:

1. Consumer Handbook
2. Consumer Handbook Acknowledgement Form

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.602
CAMHD Administration	Effective Date: July 8, 2003 History: February 17, 2002
SUBJECT: Seclusion and Restraint	Page: 1 of 10
REFERENCE: Child Health Act, Public Law No. 106-310; 42 CFR Parts 441 and 483; CMS; American Academy of Child and Adolescent Psychiatry Policy Statement; AHA, "Guiding Principles on Restraint and Seclusion for Behavioral Health Services," Feb.'99; CAMHD Sentinel Event Policy.	APPROVED: <i>Signature on Files</i>
	Chief

PURPOSE

To provide a uniform set of standards and guidelines, conducive with Centers for Medicare and Medicaid Services (CMS) requirements, for the use of restraint or seclusion for youth in out-of-home placements in Child and Adolescent Mental Health Division (CAMHD)-contracted programs.

DEFINITION

Emergency safety situation: when unanticipated youth behavior places the youth or others at serious threat of violence or injury if no intervention occurs and calls for an emergency safety intervention as defined in this section.

Emergency safety intervention: Intervention or action performed in a manner that is safe, proportionate, appropriate to the severity of the behavior, and the youth's chronological and developmental age, size, gender, physical, medical, psychiatric condition and personal history (including any history of physical or sexual abuse) to ensure the safety of the youth and others.

Seclusion: The ***involuntary*** confinement of a youth in a locked and/or secure room to ensure the safety of the youth or others. Any such isolation in a secure environment from which the youth is not potentially free to leave is considered seclusion (***e.g.***, having a staff member block the exit from the unlocked seclusion room).

Restraint: The restriction of freedom of movement through personal, drug or mechanical means in order to protect the individual from injury to self or to others. There are no distinguishing time limits among any form of restraint.

Mechanical Restraint: Any device attached or adjacent to the youth's body (***e.g.***, four-point bed restraint) that restricts a youth's movement.

Personal (Physical) Restraint: Involves any use of physical force to restrict a youth's freedom of movement. Personal escorts where the youth is willfully cooperating

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.602

CAMHD Administration

Page 2 of 10

with the escort is not considered a restraint until such time as the youth no longer intends to follow or be escorted (e.g., youth struggles with staff).

Drug (Chemical) Restraint: Any drug that:

- a. (1) Is administered to manage a youth's behavior in a way that reduces the safety risk to the youth or others;
- b. (2) Has the temporary effect of restricting the youth's freedom of movement; and
- c. (3) Is not a standard treatment for the youth's medical or psychiatric condition.

Time Out: The removal of youth from peers or rewarding situations that does not involve seclusion. Time Out is not used as a primary purpose to confine the youth, only to separate the youth from others. Such a restriction requires constant monitoring by staff. The individual is not physically prevented from leaving the designated time-out area.

Serious Injury: Any significant impairment of the physical condition of the youth as determined by qualified medical personnel, including, but not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Sentinel Event: An occurrence involving serious physical or psychological harm to anyone or the risk thereof, as defined under the categories of sentinel event codes and definitions. A sentinel event includes 1) any inappropriate sexual contact between youth, or credible allegation thereof; 2) any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof; 3) any physical mistreatment of a youth by staff, or credible allegation thereof; 4) any accidental injury to the youth or medical condition requiring attention by a medical professional or transfer to a medical facility for emergency treatment or admission; 5) medication errors and drug reactions; 6) any fire, spill of hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or 7) any incident of elopement by a youth.

POLICY

1. Each client has the right to be free from restraint or seclusion of any form that is used as a means of coercion, discipline, convenience, or retaliation. For CAMHD-contracted providers providing intensive home and community-based intervention services, the CAMHD recognizes that seclusion and restraint are not available or practicable at these

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.602
CAMHD Administration	Page	3 of 10

levels of care and therefore, are not generally used in such settings. Mental health professionals providing intensive home and community-based intervention services who might encounter potentially dangerous or otherwise unsafe situations in the community should be knowledgeable about resources and be sufficiently trained to recognize when police, mobile outreach, or emergency services are needed and then be able to assist in accessing the appropriate intervention.

2. Non-aversive interventions and positive behavioral supports shall be the ***absolute first course of action*** to ensure the safety of the youth and others. These strategies must be part of a programmatic plan to anticipate and manage a youth's unsafe behavior and must be clearly documented that such non-aversive strategies were the first course of action.
3. Evidence of the use of non-aversive interventions and positive behavior supports is the expectation of all levels of care.
4. Uses of restraint or seclusion are safety interventions ***of last resort*** and only in situations where risk of danger to the youth or others is reasonably imminent. Restraint or seclusion:
 5. Is not used as a treatment intervention.
 6. Must terminate when the emergency safety situation has ended and the safety of all can be ensured, even if the order has not expired.
 7. Is prohibited from the simultaneous use.
 8. May not exceed four (4) hours for 18-21 year olds, two (2) hours for 9-17 year olds, and one (1) hour for children under 9 years of age.
 9. Must not involve the use of mouth coverings.
 10. Must not result in harm or injury to the youth.
 11. Standing orders and as-needed (PRN) orders are prohibited.

PROCEDURE

- A. CAMHD shall contractually require that each contracted provider agency must have policies and procedures regarding the use of restraint or seclusion. The policies and procedures must include, but are not limited to, the following:
 1. The training that staff must receive prior to using restraint or seclusion with an emphasis on the serious potential for restraint or seclusion to cause injury or death.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.602
CAMHD Administration	Page	4 of 10

2. Reviewing and updating restraint and seclusion policies and procedures regularly based on clinical outcomes.
3. Agency-wide priority to use restraint or seclusion appropriately, safely and in accordance the agency's restraint and seclusion policies and procedures.
4. Adequate allocation of resources to prevent the frequent use of restraint or seclusion, and
5. Appropriate decision-making guidelines for when the use of restraint or seclusion is necessary.

B. Restraint or Seclusion Orders

1. Drug restraints must be preceded by a written order by a qualified physician. That physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.
2. Only a board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases, may order the use of restraint or seclusion.
 - a. Such orders utilize the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
 - b. Each order must include:
 - (1) The name and signature of the staff issuing the order;
 - (2) The date and time the order was issued; and
 - (3) The type of emergency safety intervention order, including the length of time authorized.
 - c. For Hospital-Based Facilities: A board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases who issued the order must conduct a ***face-to-face assessment*** of the youth's well being ***within one (1) hour of the initiation of the emergency safety intervention***.
 - d. For Non-Hospital-Based Programs: If the authorized individual who issued the order is not available, Centers for Medicare and Medicaid Services (CMS) regulations require a clinically qualified registered nurse

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.602
CAMHD Administration	Page	5 of 10

trained in the use of emergency safety interventions must conduct a ***face-to-face assessment*** of the youth's well being ***within one (1) hour of the initiation of the emergency safety intervention***.

- e. All assessments will include, but are not limited to:
 - (1) The youth's physical and psychological status;
 - (2) The youth's behavior;
 - (3) The appropriateness of the intervention measures; and
 - (4) Any complications resulting from the intervention.
- f. The board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases issuing the order must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.
- g. If the emergency safety situation continues beyond the time limit of the order for the use of restraint or seclusion , a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the person who issued the order to receive further instructions.
- h. In the absence of a board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases, verbal orders must be received by a registered nurse at the time the emergency safety intervention is initiated by staff and the physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

Each order must include:

- (1) The name of the staff issuing the order;
- (2) The date and time the order was obtained;
- (3) The type of emergency safety intervention ordered, including the length of time authorized; and
- (4) The signature of the staff issuing the order that verifies the verbal order within ***twenty-four (24) hours of the order***.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.602
CAMHD Administration	Page	6 of 10

3. If the youth's treatment team psychiatrist is available, only he or she can order restraint or seclusion.
4. If the treatment team psychiatrist is not the person issuing the order, he or she must be consulted as soon as possible and informed of the situation that required the restraint or seclusion. The date and time of this action must be documented. The program must document attempts to establish contact within 24 hours.
5. Written orders are never issued as standing orders or *as-needed* basis.

C. Monitoring of the Youth:

1. Clinical staff, trained in the use of emergency safety interventions, must be physically present, continually assessing and monitoring the physical and psychological well-being of the youth and the safe use of restraint throughout the duration of the emergency safety intervention.
2. Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside of the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the youth in seclusion. Video monitoring does not meet this requirement. The seclusion room must:
 - a. Allow staff full view of the youth in all areas of the room; and
 - b. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

D. Parental Notification

1. At admission, parents or legal guardians and youths are informed of the program's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur. The policy is communicated in a language understood by the youth and his/her parents or legal guardians.
2. Each youth and/or his legal guardian shall be provided with a copy of the program's policy. The policy will inform them of the grievance procedure if they feel that this right has been violated.
3. The youth and/or parents/legal guardian (if the youth is a minor) will acknowledge in writing that they have been informed of and understand the facility's policy. This written acknowledgement will be filed in the youth's record.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.602

CAMHD Administration

Page 7 of 10

4. The program must notify the parent(s) or legal guardian(s) that the youth has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention. Documentation of this notification, including the date and time of notification and the name of the staff person providing the notification, will be placed in the youth's file. The program must document attempts to establish contact within 24 hours.

E. Post-Intervention Debriefings

1. Within twenty-four (24) hours after the use of restraint or seclusion, the youth and all staff (except when the presence of a particular staff person may jeopardize the well-being of the resident) involved in the emergency safety intervention must have a face-to-face discussion.
 - a. Other staff and the parents or legal guardians may participate when it is deemed appropriate by the facility. If this occurs the program must conduct such a discussion in a language that is understood by the parents or legal guardians.
 - b. The discussion must provide both the youth and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the youth, or others that could prevent the future use of restraint or seclusion.
2. Within twenty-four (24) hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of:
 - a. The emergency safety situation that required the intervention, including a discussion of the ***precipitating factors*** that led up to the intervention;
 - b. Alternative techniques that might have prevented the use of the restraint or seclusion;
 - c. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
 - d. The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.
3. The agency must document in the youth's record that ***both*** debriefing sessions took place and must include the names of staff who were present for the

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.602

CAMHD Administration

Page 8 of 10

debriefing, names of staff who were excused, and any changes to the youth's treatment plan that resulted from the debriefings.

F. Medical Treatment

1. Staff must immediately obtain medical treatment from qualified medical personnel for a youth injured as a result of an emergency safety intervention.
2. The program must have affiliations or written transfer agreements with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that:
 - a. A youth will be transferred to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care.
 - b. Medical and other information needed for care of the youth will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and
 - c. Services are available to each youth twenty-four (24) hours a day, seven (7) days a week.
3. Staff must document in the youth's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention. Staff must also document any indications or allegations of injury or misconduct made by the youth along with the program's determination of appropriate follow-up.
4. Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

G. Facility/Program Reporting

1. Each agency must record, maintain, and track, any use of seclusion and restraint following the use of the most recent and current Centers for Medicare and Medicaid Services accreditation requirements. At minimum, information shall include:
 - a. The type of restraint or seclusion used;
 - b. Staff involved;

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.602
CAMHD Administration	Page	9 of 10

- c. Documentation of the verbal and/or written order;
 - d. Witnesses to the restraint/seclusion;
 - e. The time frame and duration of use;
 - f. The rationale for restraint or seclusion;
 - g. The types of less restrictive alternatives that were tried or considered; and
 - h. An assessment of the youth's adjustment during the episode and reintegration to the daily program.
 2. A sentinel event telephone call is made to CAMHD within twenty-four (24) hours of the occurrence of the restraint or seclusion. A complete documentation of the episode will follow in the CAMHD seventy-two (72) hour Sentinel Event Report, including (1) a review of the less restrictive alternatives that were considered, and (2) a reference to the debriefing with all staff involved in the event.
 3. Psychiatric residential treatment facilities must report each serious occurrence to both the State Medicaid agency and the state protection and advocacy system no later than close of business the next business day after a serious occurrence.
 - a. Serious occurrences include: Youth's death; serious injury (refer to definition, page 2 of this policy), and youth's suicide attempt.
 - b. Staff must document in the youth's record that the serious occurrence was reported and the name of the person to whom it was reported. ***A copy of this report must be maintained in the incident and accident report logs kept by the facility.***
 - c. The report must include the name of the resident, description of the occurrence, and the name, street address, and telephone number of the facility.
 - d. The facility must notify the youth's parent or legal guardian as soon as possible, but no later than twenty-four (24) hours after the serious occurrence.
- H. Education and Training
1. The facility must require staff to have ongoing education, training, and demonstrated knowledge of:

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.602
CAMHD Administration	Page	10 of 10

- a. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
 - b. The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to present emergency safety situations; and
 - c. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in youths that are restrained or in seclusion.
2. The facility must require or adhere to:
- a. Staff certification in the use of cardiopulmonary resuscitation, including annual re-certification;
 - b. Individuals who are qualified by education, training, and experience must provide staff training.
 - c. Staff training must include training exercises in which staff successfully demonstrates in practice the techniques they have learned for managing emergency safety situations;
 - d. Trained staff who have demonstrated competency before participating in an emergency safety intervention;
 - e. Documentation in individual personnel records certifying successful training and demonstration of competency. Documentation must include the date training was completed and the name of the persons certifying the completion of training;
 - f. Initial training must be a minimum of eight (8) hours in duration. Staff must receive at least eight (8) hours of training in crisis intervention annually. At least two (2) times a year, a staff person must safely demonstrate the safe use of restraint or seclusion techniques.

The availability of all training programs and materials for review by CMS, State Medicaid agency, and CAMHD.

ATTACHMENT(S): None

Review Dates: ____/____/____; ____/____/____; ____/____/____; ____/____/____/
Chief's Initials: [_____] [_____] [_____] [_____]

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	1 of 19
REFERENCE: Hawaii Administrative Rule§11-175-34; Title 45 C.F.R.§164.502(b), 164.530; 42 C.F.R. §§438.210(d)(2)(i), 438. 406(a)(1), 438.408(c)(2); HRS §334; HRS 622 (Part V), Medical Records	APPROVED: <div style="display: flex; justify-content: space-between;"> <i>Signature on File</i> July 15, 2003 </div> <div style="display: flex; justify-content: space-between;"> Chief Eff. Date </div>	

PURPOSE

To manage a systematic process for registering, tracking, resolving, and reporting grievances and grievance appeals filed by consumers, families, providers, CAMHD personnel, or other concerned parties.

DEFINITION

Aggrieved Party – The person who is filing a grievance or on whose behalf the grievance or grievance appeal is being filed.

Consumer – youth with emotional and/or behavioral challenges receiving intensive mental health services from CAMHD. For the purposes of this policy the definition of “consumer” shall include the youth, parent(s), legal guardian or designated third party representative.

HIPAA Complaint – Any assertion, whether written or oral, that an unauthorized disclosure of protected health information was made in violation of HIPAA regulations by CAMHD.

Grievance - Any oral or written communication, made by or on the behalf of a consumer, provider, and others that expresses dissatisfaction with any aspect of the Child and Adolescent Mental Health Division’s (CAMHD) operations, activities, behavior, or providers and its sub-contractor(s).

Grievance Review –A Med-Quest review process of a denied, unresolved, or unfavorable findings and conclusions made at the CAMHD grievance level.

Grievance Appeal – A written request made by, or on behalf of a non-Med-QUEST consumer or provider for review by the Grievance Committee of an adverse grievance decision; or for review by the Appeals Board of an adverse Grievance Committee decision.

Grievance Management System (GMS)- The designated system that has the responsibility to address and resolve a grievance or an appeal of an action. The Grievance Office (GO), the CAMHD Privacy Coordinator, and the FGC’s QAS are the primary GMS. As a grievance may actually be an appeal of an action, the CAMHD Clinical Services Office (CSO) is also considered a GMS.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	2 of 19

POLICY

1. CAMHD shall insure that all consumers and providers are informed of, understand, and make effective use of the grievance and appeal processes outlined in this document. The CAMHD shall inform all consumers and providers of the two portals through which they can access the CAMHD's grievance system and how he/she/they can receive assistance in communicating the grievance.
2. All concerns brought to the CAMHD's attention by anyone shall be addressed, investigated, and resolved in timely fashion as can reasonably be expected, by all parties with a vested interest in the issues at hand.
3. All CAMHD personnel shall cooperate fully with any investigation and resolution of grievances.
4. All corrective measures, deemed warranted, shall be executed in a timely manner.
5. When using or disclosing protected health information or when requesting protected health information from another covered entity, CAMHD must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 C.F.R. §164.502(b). To determine minimum necessary, refer to P&P 80.407, "Release of and Access to Confidential Information About Consumers."

PROCEDURE

I. GENERAL

Upon receipt of a call from a consumer, provider or subcontractor, the FGC or GO staff will interview the person making the call, while at the same time, using the "*CAMHD Discernment Tool*," (**See Attachment 1**) assess the type of call, e.g., inquiry, grievance, appeal, or HIPAA complaint. The FGC or GO staff shall also determine if the person at issue is a Med-QUEST enrollee (through monthly Med-Quest log to be provided by CAMHD's Quest Plan Coordinator).

- A. If the issue has been determined to be a grievance, the grievance must be filed with CAMHD within thirty (30) calendar days of the date of the occurrence. Grievances may be filed with CAMHD in the event of dissatisfaction or disagreement with:
 1. Availability of mental health services (may be discerned as an action);
 2. Delivery of services;
 3. Quality of services;
 4. Individual staff;
 5. Provider agency and its sub-contractors;
 6. Payment/Billing;

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	3 of 19

7. Any aspect of the performance of Family Guidance Center (FGC) staff; or
 8. Performance of CAMHD Central Administration Offices or staff.
- B. All referrals to the CAMHD shall include the name, address and phone number of the aggrieved party, the nature of the grievance, and documentation of actions taken prior to the referral.
- C. All expressions of dissatisfaction, regardless of the degree of perceived seriousness, relating to quality of care, availability and delivery of mental health or support services performed by the CAMHD personnel or the CAMHD contracted providers, shall be investigated and responded to by either the FGC's Quality Assurance Specialists (QAS) or the Grievance Office (GO).
- D. Grievances concerning billing, nonpayment or delay in reimbursement will be referred to, investigated and responded to by the CAMHD Billing Appeals Section.
- E. HIPAA Complaints, whether from a consumer, provider, or FGC, concerning unauthorized disclosure of protected health information (PHI) in violation of HIPAA regulations, will be initially processed through the GO (e.g., logged into database as a complaint, etc.). The complaint will then be forwarded to the CAMHD Privacy Coordinator for acknowledgement and resolution within HIPAA established Timelines. See P&P 80.603.1, "Individual Right to File Complaints About Compliance with Privacy Policy and Procedures."
- F. If the call is determined to be an inquiry, the FGC staff will answer the inquiry log the call into the shared database.

II. GRIEVANCE MANAGEMENT

There are two portals through which a consumer, provider, or its sub-contractor can access the CAMHD's grievance system. The aggrieved party can either phone their FGC and speak with staff or they can call the GO directly. Once staff has determined the type of call, the call will be forwarded to the appropriate GMS. With the exception of grievances that involve FGC QAS investigating sensitive issues, for which the QAS has the option to resolve or forward to the GO (i.e., grievance about administration, etc.), the grievance must be resolved by the GMS that received the call. **(See Flowchart Attachment 2)**

A. Family Guidance Center Portal

Upon the FGC receipt of a call by the consumer or provider, the FGC GMS will:

1. Register the call.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	4 of 19

- a. The FGC staff taking the call will record caller's name (if different from the aggrieved party, and the aggrieved person's name) and the phone number and address of the aggrieved.
 - b. The FGC staff will document the name of the assigned MHCC and the date of the call.
2. Document substance of the call.
 - a. Give consumers any reasonable assistance in completing forms, framing the issues, and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capabilities.
 - b. The FGC staff taking the call will attempt to obtain the general nature of the call. The staff taking the call will note what they perceive as the issue and forward that information to the appropriate GMS.
 - c. Complete weekly "*CAMHD Grievance Intake Form*" (**See Attachment 3**), and submit to the GO.
3. Discern whether the call is an inquiry, grievance, or an appeal of an action, and link to that GMS.
 - a. Using the "*CAMHD Discerning Tool*," the FGC staff will ask the caller a series of questions that will give a preliminary determination of whether the call is an inquiry, an appeal, or a grievance. Once the nature of the call is determined, the FGC staff will:
 - b. Forward the call to the QAS (if it is a grievance); and
 - c. Upon receipt of a grievance, FGC personnel will complete the "*Grievances Intake Form*."
 - d. Resolve the call (if the call is a simple inquiry); or
 - e. Forward the call to CSO (if the call is an appeal of an action).
 - f. If the FGC QAS determines that a grievance involves an administrator of the FGC, the QAS has the option to forward the grievance directly to the GO. Should the QAS choose to forward the grievance to the GO, this must be accomplished immediately (within 24-hours of receipt of the grievance), in order for the GO to meet the prescribed Timelines. If the QAS chooses to retain the grievance, the Timelines listed in the "Timelines" section applies and must be adhered to.

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	5 of 19

- REVISION HISTORY: 3/21/01, 3/25/03
INITIAL EFFECTIVE DATE: 12/15/99

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	6 of 19

make all appropriate referral(s), e.g., sentinel events, police, CPS, etc.

- b. Should misconduct, attributed to a provider, be determined as the result of a grievance investigation, the investigating body will also report this information to CAMHD's Credentialing Unit.

7. Timelines.

Pursuant to 42 CFR §438.406 and 45 CFR §160.306(b)(3), it is necessary to follow the timelines for each step of a grievance:

- a. *HIPAA Timelines:* 1) 180 days for aggrieved party to file from the day they knew, or should have known of the breach; and 2) 30 days to address and mitigate.
- b. *Expedited Appeals:* 1) Immediate verbal acknowledgement; 2) Two (2) days written acknowledgement; and 3) Three (3) Business days resolution. If denied, timeframe shifts to regular appeals process.
- c. *Med-Quest Grievances:* 1) Five (5) days to acknowledge; 2) Thirty (30) days to investigate and make a determination Fourteen (14) days extension for cause); 3) Thirty (30) days to file for a Grievance Review (from day of receipt of determination); and 4) Thirty (30) days for Med-Quest to conclude the Grievance Review.
- d. *Non-Med-Quest Grievances:* 1) Five (5) days to acknowledge; 2) Thirty (30) days to investigate and make determination (14 days extension for cause); and 3) Thirty (30) days for Grievance Appeals.

All timeframe references to days are "calendar" days, except where business days are mentioned. The aggrieved party or CAMHD can request an extension (if CAMHD can show how the delay is in the recipient's interest).

- 8. Notify consumers of disposition and appeal rights (emphasize importance/clarity of response).

On, or before the thirty (30)-day investigation period ends and a determination has been made by the QAS, a letter of determination shall be drafted. The content of the letter should: 1) Summarize the issue(s) of the grievance; 2) Explain the decision, the decision making process and logic; and 3) Conclude with a paragraph stating the Aggrieved Party's right to

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	7 of 19

file for a Med-Quest Grievance Review. The QAS will then forward copies of the determination letters accordingly:

- a. The original to the Aggrieved Party;
- b. One copy to the GO; and
- c. One copy to file.

9. Data tracking/Reporting.

- a. The QAS will complete a grievance intake form and log the grievance; and
- b. The QAS will forward the log and intake form (each Monday of the following week) to the GO. The GO will enter the grievance into the database.
- c. Report all negative grievances in the log and fax to the GO, regardless if the form contains no data.
- d. The Care Coordinator or QAS (or PHAO in the QAS's absence) of each FGC is responsible for faxing the "*CAMHD Weekly Information Log*" (see **Attachment 5**) for grievances, grievance appeals, and HIPAA complaints, generated the previous week to the GO by 4:00 p.m. each Monday. If the Weekly Information Log contains a consumer's protected health information (PHI), proper faxing protocol must be followed pursuant to P&P 80.402, "Confidentiality, FAX Transmission."

B. Grievance Office (GO) Portal

Central Administrative Responsibilities include:

1. Grievances concerning fiscal matters by the GO are forwarded to the designated Fiscal Personnel for investigation and response. That Fiscal Staff is responsible for inputting case information in the Grievance Tracking Database System, and for following the procedures in this manual to initiate and complete the investigation.
2. For cases that are referred to the GO for investigation, the GO will assist the aggrieved party in determining the substantive issue(s) of the case and provide the aggrieved party with a written acknowledgement within five (5) workdays from receipt of the grievance. All information will be recorded in the Grievance Tracking Database System. Investigations will begin within seven (7) workdays from the date the complaint is filed.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	8 of 19

3. The investigative and resolution portion of the complaint process will not exceed thirty (30) calendar days. It will begin with a discussion with the Care Coordinator regarding the child's history if the nature of the complaint is specific to a child.
4. Extensions are permitted only if exceptional circumstances exist with respect to a particular grievance. Any extension cannot exceed 14 calendar days. The investigating party will maintain documentation on extensions, including the rationale for the extension and the new date for issuance of findings. Exceptional circumstances may include but are not limited to:
 - a. The need to review documents or information that will not be available until after the thirty (30)-day time limit;
 - b. Unusually complex issues or extraordinarily high volume of documents;
 - c. Extensive number of issues; or
 - d. Temporary unavailability of individuals with information critical to the complaint.
5. In resolving grievances, the investigating party will follow the CAMHD "Interagency Performance Standards and Practice Guidelines" and all applicable laws. Other Central Administration or FGC staff may be consulted or asked to assist in this fact-finding process. On-site reviews by Clinical Services and Performance Management may be requested as necessary.
6. Response: The investigating party (FGC, GO, or Fiscal Section) will respond to the aggrieved party in writing. The "*Letter of Resolution*" (**See Attachment 6**) must include the following information:
 - a. Name and address of the aggrieved party;
 - b. Date of notification and date when grievance was originally filed with the GO;
 - c. Name of the staff investigator;
 - d. Findings;
 - e. Corrective action plan, if needed, and
 - f. A concluding paragraph (for Med-QUEST consumers only) that states: "This letter represents CAMHD GO's resolution of the issues raised by your grievance. If you wish to pursue this matter to the next level, you may do so by submitting a request (written or

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	9 of 19

oral) for a Grievance Review with the Med-QUEST Office within thirty (30) calendar days of this notice. You can call (808) 692-8093 or 692-8096 (ask to speak with the QUEST Plan Liaison). Or, you can write in care of: Med-QUEST Division, Health Coverage Management Branch, 601 Kamokila Blvd., #506, Kapolei, Hawaii, 96707.”

- g. For non-Med-QUEST consumers, the concluding paragraph must state: *“This letter represents CAMHD GO’s resolution of the issues raised by your grievance. If you wish to pursue this matter to the next level, you may do so by submitting your first level appeal to the CAMHD GO within 30 days of this notice. The CAMHD Grievance Committee will hear the first level appeal. Please send your written request together with any supporting documentation to the CAMHD Grievances and Appeals Office, 3627 Kilauea Ave., Room 101, Honolulu, HI 96816. Should you have any questions you may contact the GO at 733-8495.”*
- h. In grievances involving direct service providers and delegated activities contractors, a copy of the Resolution letter should be provided to the Credentialing Unit or other CAMHD administrative section as applicable (*i.e.*, performance monitoring unit).

7. Calls To The GO

Upon the GO receipt of a call by the consumer, third party representative, or provider, the GO GMS will:

- a. Register the call.
 - 1) The GO taking the call will record:
 - 2) Callers name (if different from the aggrieved party, and the aggrieved person’s name), phone number and address of the aggrieved party;
 - 3) The consumer’s client record (CR) number and/or Med-Quest ID number;
 - 4) The assigned MHCC;
 - 5) The date of the call; and
 - 6) Log grievance into the GO Database.
- b. Document substance of the call.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	10 of 19

The GO staff taking the call will attempt to obtain the general nature of the call and note what they perceive as the issue and either resolve the grievance within prescribed timelines, or forward that information to the appropriate GMS.

- c. Discern whether the call is an inquiry, grievance, or an appeal of an action, and link to that GMS.
 - 1) Using the Discerning Tool, the GO staff will ask the caller a series of questions that will give a preliminary determination of whether the call is an inquiry, a grievance, or an appeal of an action. Once the nature of the call is determined, the GO will:
 - 2) Resolve the call (if the call is a simple inquiry);
 - 3) Address the grievance as noted above;
 - 4) Should a grievance be retained by the GO, the GO must send a letter of acknowledgement to her aggrieved party within five (5) days from receipt of the grievance.
 - 5) Forward the call to CSO (if the call is an appeal of an action); or
 - 6) Forward the complaint to the CAMHD Privacy Coordinator (if the call is a HIPAA issue).
- d. If the call is determined to be a grievance, investigate the substance including:
 - 1) Clinical issues involved:
 - (a) Obtain issues form the aggrieved party;
 - (b) Ask the caller what they expect the outcome to be, e.g., just to inform CAMHD, investigate, etc.; and
 - (c) Interview MHCC and provider.
 - 2) Obtain all pertinent documentation:
 - (a) Request all necessary documents in CAMHD's possession from MHCC or QAS (i.e., IEP, CSP, MHTP, etc.);
 - (b) Request other necessary documents not in CAMHD's possession (written statements,

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	11 of 19

impressions, etc.), from providers, teachers, etc.;
and

- (c) Consult the CAMHD CASSP Principles and IPSPG.
- 3) Seek clinical, administrative, or other consultation from:
 - FGC Clinical Director;
 - MHS and Branch Chief; and/or
 - CAMHD Medical Director (CSO).
- e. Make a determination based upon the information obtained from the investigation, within thirty (30) calendar days from receipt of the call, the GO will conclude the investigation and make a determination on the issue(s).
- f. Managing clinically urgent grievances.
 - 1) The staff that makes the discovery must address all clinically urgent grievances, such as abuse. That staff is obligated to make all appropriate referral(s), e.g., sentinel events, police, CPS, etc.
 - 2) Should misconduct, attributed to a provider, be determined as the result of a grievance investigation, the investigating body will also report this information to CAMHD's Credentialing Unit.
- g. Timelines.

Pursuant to 42 CFR §438.406 and 45 CFR §160.306(b)(3), it is necessary to follow the timelines for each step of a grievance:

 - 1) *HIPAA Timelines:* 1) One hundred and eighty (180) days for aggrieved party to file from the day they knew, or should have known of the breach; and 2) thirty (30) days to address and mitigate.
 - 2) *Expedited Appeals:* 1) Immediate verbal acknowledgement; 2) two (2)-day written acknowledgement; and 3) three (3) Business Day resolution. If denied, timeframe shifts to regular appeals process.
 - 3) *Med-Quest Grievances:* 1) Five (5) days to acknowledge; 2) thirty (30) days to investigate and make a determination fourteen (14) days extension for cause; 3) thirty (30) days

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	12 of 19

to file for a Grievance Review (from day of receipt of determination); and 4) thirty (30) days for Med-Quest to conclude the Grievance Review.

- 4) *Non-Med-Quest Grievances:* 1) five (5) days to acknowledge; 2) Thirty (30) days to investigate and make determination fourteen (14) days extension for cause); and 3) Thirty (30) days for Grievance Appeals.

All timeframe references to days are “calendar” days, except where business days are mentioned. The aggrieved party or CAMHD can request an extension (if CAMHD can show how the delay is in the recipient’s interest).

- h. Notify consumers of disposition and appeal rights (emphasize importance/ clarity of response).

Once the GO staff has made a determination, a letter of determination shall be drafted. The content of the letter should: 1) Summarize the issue(s) of the grievance; 2) Explain the decision, the decision making process and logic; and 3) Conclude with a paragraph stating the Aggrieved Party’s right to file for a Med-Quest Grievance Review. The GO will then forward copies of the determination letters accordingly:

- 1) The original to the Aggrieved Party;
- 2) One copy to the Supervisor of Performance Management; and
- 3) One copy to file.

- i. Data tracking/Reporting.

- 1) The GO staff will receive and track the intake form from the QAS and log and enter the data into the GO database; and
- 2) The GO staff will enter the grievance and its resolution into the Grievance database.
- 3) The GO will generate all tracking and trending reports/analysis and submits the reports to the appropriate committees, i.e., PISC Report and Med-Quest Division Report.

III. ACTIONS

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	13 of 19

- A. If the FGC staff determines that the nature of the call is regarding an action, the call is immediately referred to the QAS.
- B. The QAS will (within twenty-four (24) hours of receipt of call) forward the Aggrieved Party to the Clinical Services Office (CSO).
- C. Appeals, along with applicable Timelines, are addressed pursuant to P&P 80.604, "Denial of Services, Appeals, and the State Fair Hearing Process."
- D. If the GO determines that the nature of the call is in regard to an action, the GO will immediately forward the call, along with all pertinent information the GO receives, to CSO for resolution.

IV. OTHER CENTRAL ADMINISTRATION OFFICE (CAO) DUTIES

- A. DOE: The GO may assist the Complaints Resolution Office of the Department of Education to investigate mental health related complaints about Felix youths filed with the DOE. The investigation will follow DOE complaint procedures.
- B. Files: All grievances files will be maintained in a secured file marked with the grievance case number and the name of the aggrieved party.
- C. QAS Training on the Grievances Process: The CAO will train all QAS on the grievance process in order to assure consistent application of the process and procedures at the FGC level. The training will occur annually, at new employee orientation for the QAS, and when changes in the grievances process warrants re-training. The training will also explain the function and procedural process of grievances and appeals at the GO level. Training will include, but is not limited to:
 - 1. Logging all grievances received at the FGC level, whether resolved by the QAS or referred to the GO;
 - 2. The completion and submission of weekly reports to the GO for the purpose of tracking and trending;
 - 3. The role of the FGCs and the GO in the grievance process; and
 - 4. The exchange of critical case information between the GO and QAS.

V. GRIEVANCE REVIEW (Med-QUEST)

- A. Consumers, families or providers who disagree with the findings and decisions at the grievance level may file for a "Grievance Review" with the Med-QUEST Division. Grievances reviews must be filed within thirty (30) calendar days of the date stated on the GO's findings and decisions letter.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	14 of 19

1. All requests for a grievance review must be submitted to the Med-QUEST Division. Med-QUEST consumers can either call or write to request a grievance review at:

Med-QUEST Division
Health Coverage Management Branch
601 Kamokila Blvd., #506
Kapolei, Hawaii 96707
(808) 692-8093 or 692-8096

The Med-QUEST Plan Liaison must review the grievance and contact the recipient with a determination within thirty (30) calendar days from the day he/she received the request for a grievance review.

2. The grievance review determination made by the Med-QUEST staff is final.

VI. GRIEVANCE (Non-Med-QUEST)

The procedure and applicable Timelines for non-Med-QUEST grievances will be the same as Med-QUEST grievances. However, the appeal rights for non-Med-QUEST consumers will be handled according to internal CAMHD appeals protocol exclusive of Med-QUEST Division. Non-Med-Quest grievances must be filed with the GO within thirty (30) days of its occurrence or thirty (30) days from the time the aggrieved party knew, or should have known, of the grievance.

- A. Investigation of the grievance will be initiated within seven (7) workdays from the date the grievance is filed. The grievance process will not exceed thirty (30) calendar days. Extensions are permitted only if exceptional circumstances exist with respect to a particular grievance. Any extension will be for a specified duration of time, not to exceed fourteen (14) days. The investigating party will maintain documentation on extensions, including the rationale for the extension and the new date for issuance of findings. Exceptional circumstances may include but are not limited to:
 1. The need to review documents or information that will not be available until after the thirty (30) calendar day time limit;
 2. Unusually complex issues or extraordinarily high volumes of documents;
 3. Extensive number of issues;
 4. Temporary unavailability of individuals with information critical to the grievance; and
 5. Scheduling conflicts of the Grievance Committee.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	15 of 19

B. Investigation Process (Non-Med-QUEST)

1. The GO will receive written grievances, forwarding those that are fiscally related to the Fiscal Office. Information related to all grievances shall be reviewed to insure all areas of the complaint processes have been exhausted prior to opening the grievance. Further fact-finding shall be conducted of any significant new information brought forth by the written grievance.
2. The GO or the Fiscal Office, as applicable, will notify the grieving party in writing of the receipt of the grievance. Either the GO or the Fiscal Office as applicable shall enter case information into the shared Grievance Tracking Database System.
3. The GO shall prepare non-fiscal grievance reports for the Grievance Committee's review, including any applicable new fact-finding information; the Fiscal Office will do the same for fiscal-related grievances.
4. All grievances pursuant to 42 CFR §438.400(b)(6), shall be addressed by the GO following the established guidelines and Timelines defined by Med-Quest.

C. The Grievance Committee (Non-Med-QUEST)

1. Grievances are presented to the CAMHD Grievance Committee at the next regularly scheduled meeting following the conclusion of the investigation. The Committee generally meets on the first and third Tuesday of each month. The Committee will consist of a quorum of the following members: Clinical Director, Performance Management Supervisor, Provider Relations Officer, Family Guidance Center Representative, Fiscal Representative and a parent representative.
2. The Committee will render a decision upon hearing and reviewing the grievance report. This determination will be reported in writing to the grieving party within ten (10) working days of the decision. The party responsible for presenting the grievance at the Committee meeting will prepare the response. The written response to the grieving party must include the following information:
 - a. Name and address of the grieving party;
 - b. Findings of the Grievance Committee;
 - c. Corrective action plan;
 - d. Agreement, if applicable; and

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	16 of 19

- e. For all adverse decisions to a grievance, a concluding paragraph that notifies the grieving party of their right to file an appeal, how to file the appeal, the timeline to filing, and the address of the GO.
- f. In the matter of fiscal grievances, CAMHD reserves the exclusive right to determine whether or not to engage in a settlement process.
- g. The grievance files will be maintained in a file marked with the grievance case number and the name of the grieving party. These files will be controlled as sensitive material and will be maintained on premises by the GO Office in a secure file cabinet.

D. Settlement Process (Non-Med-QUEST)

- 1. The Grievance Committee will consider the following factors in determining whether a settlement shall be offered based on the following factors:
 - a. Whether denial of the grievance will have a significant impact on the agency's ability to continue providing services to Felix identified children and youths. The existence of a significant impact will be determined by looking at the following:
 - 1) The amount requested/being appealed.
 - 2) The percentage of the appealed amount to the total amount the grieving party has billed CAMHD encompassing the preceding year to date.
 - b. Acceptable alternative documentation as proof of the provision of services consisting of:
 - 1) Clear evidence that the services in question were provided.
 - 2) The seriousness of the billing deficiency in relation to the compliance with the documentation requirements of the Contract Management Standards, per level of care at issue.
 - c. The lack of evidence of a pattern of fraud and/or abuse.
 - d. The impact on CAMHD's ability to provide services to Felix identified children and youths.
- 2. Following a compilation of documentation related to all of the above factors, the Billing Appeals Office will present a written summary accompanied with a recommendation for offer of settlement for the Grievance Committee's consideration and decision.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	17 of 19

3. It is within the CAMHD's sole discretion to determine the amount offered to a grieving party.
4. The Grievance Committee's decision stands in the event a settlement is not offered.
5. Following a decision to offer a settlement, the Billing and Appeals Office will send a written response to the grieving party that includes the following information:
 - a. Name and address of the grieving party;
 - b. Findings of the Grievance Committee;
 - c. Corrective action plan, if needed; and
 - d. Agreement, if needed.

E. APPEALS (Non-Med-QUEST)

The aggrieved party may file a written appeal (2nd level appeal) with the GO if they disagree with the determination of the Grievance Committee. An appeal of the Committee's decision must be filed within thirty (30) calendar days of the date stated on the determination letter. It must include: (a) The reasons the complainant believes the Grievance Committee's decision was in error; (b) All necessary facts and documents to support the reasons for appeal; (c) Any new information that was previously unavailable together with the reasons why the new information was not previously available; and, (d) If applicable, a description of any extenuating circumstances. The Complaint's Office may dismiss a request for appeal if the request for appeal does not meet the foregoing requirements, for good cause, or where the request for appeal is frivolous and without merit. Any dismissal of a request for appeal shall be in writing and state the reasons for dismissal.

1. The GO or the Fiscal Office as applicable, upon receipt of the written appeal, will review the information to ensure all areas of the grievance process have been exhausted prior to opening the appeal. The applicable office will enter all pertinent information into the Grievance Tracking Database system and the appealing party notified in writing of the receipt of the appeal.
2. The appealing party has the right to submit documentation in support of the appeal or appear in person before the Appeals Board. The GO or the Fiscal Office as applicable will inform the appealing party of the appeal date as soon as one can be scheduled.

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	18 of 19

3. A synopsis of the case on appeal will be prepared by the GO (non-fiscal cases), or the Fiscal Section (fiscal cases). The GO will coordinate the forwarding of the synopsis to the Appeals Board for briefing purposes.
4. Pursuant to HAR §11-175-34(c), the appeals process will not exceed thirty (30) calendar days from receipt of the appeal. Extensions are permitted only if exceptional circumstances exist with respect to a particular appeal. Any extension will be for a specific amount of time. The GO or the Fiscal Office as applicable will maintain documentation on the extension, including the rationale for the extension and the new date for issuance of findings. Exceptional circumstances may include but are not limited to:
 - a. The need to review documents or information that will not be available until after the 30-day time limit.
 - b. Unusually complex issues or extraordinarily high volume of documents;
 - c. Extensive number of issues; or
 - d. Temporary unavailability of individuals with information critical to the appeal; and
 - e. Scheduling conflicts of the Appeals Board.
5. If CAMHD extends the timelines, it must – for any extension not requested by the consumer, give the consumer written notice of the reason for the delay.
 - a. The CAMHD Appeals Board consists of the Deputy Director for Behavioral Health, the CAMHD Chief and the Medical Director.
 - b. After the consumer files an appeal and before the Appeals Board hears the case, the GO and the Fiscal Section may engage in efforts at settlement with the appealing party. The procedures for settlement outlined in the “Settlement Process Section,” will be followed.
 - c. The Appeals Board, after hearing and reviewing the appeal, will render a decision. This decision will be reported in writing to the appealing party within ten (10) working days of the decision. The decision of the Appeals Board will be the final response from the CAMHD.
 - d. Appeal files will be maintained in a file marked with the appeal case number and name of the appealing party. These files will be

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

SUBJECT: Grievances and Grievance Appeals	Number:	80.603
	Page:	19 of 19

controlled as sensitive material and will be maintained on premises
in a secure file cabinet.

F. DISMISSAL (Non-Med-QUEST)

The CAMHD has the discretion to dismiss a grievance or appeal at any time upon written request from the initiating party. Or when a complainant has failed to pursue or present their case, after reasonable notice by the CAMHD, after one (1) year of the initiation of the grievance or appeal. Upon a showing of good cause, the aggrieved party can request a reinstatement of their case.

VII. CONFIDENTIALITY/HANDLING

Access to records will be limited to those staff members directly involved in the investigation of the grievance or appeal as well as managerial staff on a need to know basis. When not in use, records will be stored in a locked drawer or cabinet. Records will not be left unattended or unsecured in the workplace, or in a position or location easily accessible to non-staff members.

VIII. RECORD RETENTION

All records of persons served by CAMHD will be maintained in a protected and confidential manner for time periods consistent with applicable laws.

- A. Records pertinent to minors shall be maintained for a period of twenty-five (25) years from the date of majority.
- B. The CAMHD will maintain records of all grievances and appeals for two years on site (current and last calendar year), with the remaining years being maintained in secure storage.

ATTACHMENTS:

- 1. CAMHD Discernment Tool
- 2. CAMHD Grievance Flow Chart
- 3. CAMHD Grievance Intake Form
- 4. CAMHD Sample Letter of Acknowledgement
- 5. CAMHD Weekly Grievance Information Log
- 6. CAMHD Letter of Resolution

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.604

CAMHD Administration

Page 1 of 8

SUBJECT: Denial of Services, Appeals, and the Med-Quest Hearing Process

REFERENCE: 42 CFR §§438.400-483.424; 42 CFR §431.244(f)(1)(i); HRS §91-9

APPROVED:

Signature on File

14 Jul 03

Chief

Eff. Date

PURPOSE

To establish and outline a process whereby all consumers may appeal an action by Child and Adolescent Mental Health Division (CAMHD) and to define a procedure where Quest enrollees can exercise his/her right to access the Department of Human Services Fair Hearing process.

DEFINITION

“Action” – (1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized services; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of CAMHD to act within the timeframes provided in §438.408(b); or (6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right under §438.52(b)(2)(ii), to obtain services outside the network.

“Appeal” – A request for review of an action, as “action” is defined in this section.

“Appellant” – An individual who files an appeal. This can be the parent/legal guardian, provider, or an individual or personal care physician who has been designated to act on behalf of the youth, parent, or legal guardian.

“Consumer” - Youth with emotional and/or behavioral challenges receiving intensive mental health services from CAMHD. For the purpose of this policy the definition of consumer includes the youth, parent(s), legal guardian or designated third-party representative.

“Department of Human Services Hearing” – The term “hearing” means any formal proceeding for the determination of the legal rights of specific parties which is authorized by law or rules in a matter which is initiated by action taken, or to be taken, by CAMHD or which may be initiated by a petition or application for the granting of any right, privilege, authority or relief from or after administrative action.

“Enrollee” – A consumer who QUEST eligible and is enrolled in CAMHD’s behavioral health plan.

“Grievance” – An expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled by CAMHD’s Grievance Office (GO)

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.604

CAMHD Administration

Page 2 of 8

and access to the Med-Quest State Fair Hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the consumer's rights.) The GO will follow established procedures and timeframes to address and resolve grievances as outlined in P&P 80.603, "Grievances, and Appeals."

POLICY

1. CAMHD shall give notice to all consumers of their right to appeal all actions by CAMHD and the right of enrollees to access the Department of Human Services (DHS) Fair Hearing process.
2. CAMHD shall also assist the consumer in drafting the appeal, filing the appeal, and in keeping within all specified timeframes.
3. CAMHD will supply all provider(s) and its sub-contractor(s) with information regarding the consumer's right to file an appeal, the enrollee's right to a DHS Fair Hearing process, and the enrollee's ability to file for an external review with the Hawaii Insurance Commissioner.

PROCEDURE

DENIAL (ACTION) PROCESS

1. **Review Request for Services**

Youth who have been identified by an IEP/MP/CSP team to require intensive mental health services are enrolled with the Family Guidance Center (FGC) located in the school district of their home school. Once the team identifies the level of care needed, the mental health care coordinator begins the service authorization process.

2. **Authorization of Services**

Once the IEP/MP/CSP team decides on the appropriate level of care the Mental Health Care Coordinator (MHCC) generates a service authorization. For levels of care higher than Therapeutic Group Homes (Hospital-Based Residential, Community-Based Residential I, Community-Based Residential II and Community-Based Residential) the FGC Clinical Director reviews and approves initial authorizations. The CAMHD Utilization Management Program reviews and approves service authorizations for Hospital-Based Residential. The FGC Clinical Director will review all levels of care at some point for re-authorizations.

3. **Expedited Authorization Decisions**

For cases in which a provider indicates, or CAMHD determines, that following the standard timeframe could seriously jeopardize consumer's life or health or ability to

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.604

CAMHD Administration

Page 3 of 8

attain, maintain, or regain maximum function, CAMHD must make an expedited authorization decision and provide notice as expeditiously as the consumer's health condition requires and no later than three (3) working days (72-hours) after receipt of the request for services. However, depending upon the severity of the situation, e.g., life threatening, etc., the three (3) day timeframe will be waived and the decision will be made within twenty-four (24)-hours of receipt, if not immediately.

4. Denial (Action)

After consideration of a request for services, and CAMHD has determined that such services are either not therapeutic, excessive, or no longer needed, the MHCC will issue the determination in the form of an "action." Depending upon the decision making body (the Family Guidance Center or CAMHD's Utilization Management Program), the decision making body will contemporaneously send the Notice of Action to the consumer and a copy of the notice to the Clinical Services Office (CSO).

5. Notice of Action

The Notice of Action will be written and made available in sixth Grade level English and in the prevalent non-English languages spoken through out the State. CAMHD will make oral interpretation services of the notice available free of charge to each potential consumer and consumer. Oral interpretation services will be provided to all non-English languages, not just those languages that CAMHD determines as prevalent.

The Notice of Action will contain the following:

- A. The action CAMHD or its contractor has taken or intends to take.
- B. The reasons for the action.
- C. The consumer's or the provider's right to file an appeal with CAMHD-CSO.
- D. The enrollee's right to request a DHS Fair Hearing, if Quest eligible.
- E. The procedures for exercising the rights specified in this paragraph.
- F. The circumstances under which expedited resolution is available and how to request it.

The following timeframes are applicable to the corresponding actions:

- A. For termination of services, suspension, or reduction of previously authorized services, CAMHD will mail notice of action to consumer at least ten (10) calendar days before the date of action.
- B. For denial of payment, at the time of any action affecting the claim.
- C. For standard service authorization decision that deny or limit pre-determined services, CAMHD will provide notice as expeditiously as the consumer's health

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.604

CAMHD Administration

Page 4 of 8

conditions require and within State-established timeframes that may not exceed (ten) 10 calendar days.

- D. For expedited service authorization decisions, if a provider indicates that, or CAMHD determines that, following the standard timeframe could seriously jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum function, CAMHD must make an expedited appeal decision and provide notice as expeditiously as the consumer's health condition requires and no later than three (3) business days after receipt of the request for services.

6. **Benefits Continue Pending Resolution of Appeal.**

The notice of action will contain information regarding the consumer's right to have benefits continue pending resolution of the appeal, and how to request that benefits be continued. If the consumer is Quest eligible, the circumstances under which the enrollee may be required to pay for the costs of the provided mental health services will also be included in the notice of action.

APPEAL PROCESS

1. **Where and how to file an appeal**

Filing of an appeal can be in verbal or written form; however, if the appeal is filed verbally, it must be followed by a written appeal. The appeal can be filed with the Family Guidance Center Quality Assurance Specialist or with CAMHD CSO.

2. **The following timeframes are applicable to the corresponding events:**

- A. Upon receipt of the notification of the action, the consumer has thirty (30) calendar days to file an appeal.
- B. Once an appeal has been filed, either verbally or in writing, CAMHD must render a written letter to the appellant stating that the appeal is being reviewed within five (5) business days.
- C. If a verbal appeal is filed, the appellant has ten (10) calendar days to submit the appeal in writing.
- D. In handling an appeal, CAMHD will give consumers any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

3. **CAMHD Appeal Review**

- A. Once the appeal is received, CAMHD will assign a team of two (2) psychiatrists to review the appeal. The psychiatrists who make decisions on appeals are individuals:

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.604
CAMHD Administration	Page 5 of 8

- a) Who were not involved in any previous level of review or decision-making; and
 - b) Who, if deciding any of the following, are health care professionals who have appropriate clinical expertise, as determined by the State, in treating the consumer's condition.
 - i. An appeal of a denial that is based on lack of medical necessity.
 - ii. A grievance regarding denial of expedited resolution of an appeal.
 - iii. An appeal that involves clinical issues.
 - B. Written notification of the appeal decision will be submitted to the consumer and all related parties within thirty (30) days of filing the appeal.
4. **The Notice of Appeal Finding will contain the following:**
- A. The finding of the appeal.
 - B. The reasons for the decision.
 - C. The consumer's or the provider's right to file a final appeal.
 - D. The enrollee's right to request an external review with the Hawaii Insurance Commissioner if Quest enrolled.
 - E. The procedures for exercising the rights specified in this paragraph.
5. **Final Appeal for Non-Quest Enrolled Youth**
- A. Youth who are not enrolled in Quest can appeal one last time. This appeal shall be filed with the CAMHD CSO and reviewed by the CAMHD Appeal Board. The appeal can be filed verbally or in writing. If a verbal appeal is filed, the appellant has ten (10) calendar days to submit the appeal in writing.
 - B. The Appeal Board is made up of the following:
 - a) CAMHD Chief
 - b) A psychiatrist who was not involved in the original determination or the initial appeal
 - c) A representative from the Office of the Director of Health
6. **The following timeframes are applicable to the corresponding events:**
- A. Upon receipt of the notification of the action, the consumer has fourteen (14) calendar days to file a final appeal.
 - B. The Appeal Board will render a final written determination within thirty (30) calendar days of filing the second appeal.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.604

CAMHD Administration

Page 6 of 8

7. **Final Appeal for Quest Enrolled Youth**

- A. Youth who are enrolled in Quest can appeal one last time. This appeal shall be filed with the State of Hawaii Department of Human Services, State Fair Hearing. The appellant can also request an external review by the Hawaii Insurance Commissioner.
- B. In handling an appeal, CAMHD will give consumers any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

8. **CAMHD's Process for Appeals will:**

- A. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the consumer or the provider requests expedited resolution.
- B. Provide the consumer a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (CAMHD will inform the consumer of the limited time available for this in the case of expedited resolution.)
- C. Provide the consumer and his or her representative opportunity, before and during the appeals process, to examine the consumer's case file, including
 - a) medical records; and
 - b) any other documents and records considered during the appeals process.
- D. Include, as parties to the appeal:
 - a) The consumer and his or her representative; or
 - b) The legal representative of a deceased consumer's estate.
- E. For standard resolution of an appeal and notice to the affected parties, CAMHD will establish a timeframe that is no longer than thirty (30) calendar days from the day CAMHD receives the appeal. This timeframe may be extended up to fourteen (14) calendar days.
- F. Notice of Resolution (Appeals) –Content
- G. The written notice of resolution to an appeal shall contain the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the enrollee the notice of resolution must contain:
 - a) The right to request a Med-Quest Hearing, the Med-Quest contact person, their address and phone number, and how to do so;

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.604
CAMHD Administration	Page	7 of 8

- b) The right to request to receive benefits while the hearing is pending, and how to make the request; and
 - c) The enrollee may be held liable for the cost of those benefits if the hearing decision upholds CAMHD's action.
- H. CAMHD will supply all providers, and its sub-contractor(s), with information about the enrollee's right to file an appeal or a Med-Quest Hearing, at the time they enter into a contract. This information will include the following:
- a) For State (DHS) Fair Hearing:
 - i. The right to hearing;
 - ii. The method for obtaining a hearing; and
 - iii. The rules that govern representation at the hearing.
 - b) The right to file a grievances and appeals.
 - c) The requirements and timeframes for filing a grievance or appeal.
 - d) The availability of assistance in the filing process.
 - e) The toll-free numbers that the consumer can use to file a grievance or appeal by phone.
 - f) The fact that, when requested by the enrollee:
 - g) Benefits will continue if the enrollee files an appeal or a request for a Med-Quest Hearing within the timeframes specified for filings; and
 - h) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
 - i) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
9. **Expedited Resolution of Appeals (42 CFR §438.410)**
- A. CAMHD will establish and maintain an expedited review process for appeals, when CAMHD determines (for a request from the consumer) or the provider indicates (in making the request on the consumer's behalf or supporting the consumer's request) that taking the time for a standard resolution could seriously jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum function.
 - B. The timeframe for the expedited appeal process is three (3) days; however, depending on the severity of the situation, e.g., life threatening, etc., the three (3) day timeframe will be waived and the decision will be made within twenty-four (24) hours of receipt, if not immediately.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.604
CAMHD Administration	Page	8 of 8

- C. CAMHD will ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an consumer's appeal.
- D. If CAMHD denies a request for an expedited resolution of an appeal, CAMHD will:
 - a) Transfer the appeal to the timeframe for standard resolution that is no longer than forty-five (45) days from the day CAMHD receives the appeal (with applicable extension).
 - b) Make reasonable efforts to give the consumer prompt oral notice of the denial, and follow-up within two (2) calendar days with a written notice.

ATTACHMENT(S):

- 1. Denial and Appeal Flow-Chart
- 2. Notice of Action
- 3. Letter stating receipt of verbal appeal
- 4. Letter stating receipt of written appeal
- 5. Notice of Appeal Finding for Non-Quest Youth
- 6. Notice of Appeal Finding for Quest Youth

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.705
CAMHD Administration	Effective Date: March 19, 2003 History: 5/15/97
SUBJECT: Accessing Services from CAMHD Contract Providers	Page: 1 of 3
REFERENCE: Interagency Performance Standards and Practice Guidelines; Performance Management Monitoring Plan.	APPROVED: <i>Signature on File</i>
	Chief

PURPOSE

To establish standardized protocols to guide the Family Guidance Center (FGC) Care Coordinator in assessing authorized mental health services from Child and Adolescent Mental Health Division (CAMHD) contract providers.

DEFINITION

"Mental Health Care Coordinator" (MHCC) - The designated CAMHD professional who is responsible to facilitate mental health service delivery.

"Contract Provider" - Community-based private provider agencies which have entered into a formal contract relationship with CAMHD.

POLICY

1. All clients registered with a FGC shall have a designated MHCC who is responsible for arranging for coordinated service delivery and authorizing mental health services from Contract Providers.
2. The MHCC shall refer clients for evaluation and treatment services from CAMHD's Contract Providers as guided by the CAMHD Contract Provider Directory and CAMHD's Clinical Treatment Standards Manual while giving particular attention to services which are most appropriate to the client and family.

In all cases, decisions made by Individualized Educational Program (IEP) teams and Coordinated Service Planning (CSP) team, or other treatment planning teams, will be the guiding factor for service procurement.
3. The MHCC shall arrange service delivery from the Contract Provider agency by calling the contact representative identified in the directory.

The choice of a contracted provider will be based on the assessment of the most appropriate provider given the needs of the client and to ensure seamless care.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.705
CAMHD Administration	Page	2 of 3

4. The Contract Provider has responsibility to assign a clinician to meet the client's specific needs, and to notify the client/family and MHCC of referral acceptance, and to make service arrangements.
5. CAMHD's Performance Management Office shall routinely monitor referrals to all Contract Providers to verify that all providers are credentialed CAMHD Contract Providers.
6. MHCCs or other team members who have particular concerns about a Contract Provider or a particular staff person, are responsible to report this information to the FGC Branch Chief and/or the CAMHD Performance Management staff. The FGC Branch Chief shall evaluate the situation, and shall interface with CAMHD Performance Management personnel to formally investigate as needed. Those concerns may relate to clinical or administrative issues.
7. In the event there are insufficient community-based providers, CAMHD shall develop actions to ensure that all clients receive services.
8. MHCCs are responsible to notify the Branch Chief verbally and in writing, of any specific concerns of ethical business or clinical practices involving community providers. The Branch Chief shall interface with CAMHD's Compliance Officer to investigate the situation.

PROCEDURE

1. Upon admission to FGC, the assigned MHCC shall review data received and convene a CSP team meeting.
2. Based upon CSP development, the MHCC contacts a Contract Provider to arrange service delivery. Attention is paid to convenience to the family, specialty areas, and locations.
3. The Contract Provider shall contact the family. The MHCC shall facilitate this meeting as needed.
4. The Contract Provider shall contact the FGC to notify the MHCC of the clinician assigned and the appointment date(s).
5. The MHCC shall contact the assigned Contract Clinician after the initial appointment date to verify that services were rendered.
6. The MHCC shall contact the family to verify satisfaction of services rendered and that needs have been met.
7. The Contract Provider shall complete required reports in accordance with CAMHD's IPSPG.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.705

CAMHD Administration

Page 3 of 3

8. Ongoing service authorization interface shall occur between the Contract Provider and the MHCC.

ATTACHMENTS: None

Review Dates: ____/____/____; ____/____/____; ____/____/____; ____/____/____/

Chief's Initials: [_____] [_____] [_____] [_____] [_____]

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.805
CAMHD Administration	Effective Date: March 31, 2003 History: 7/1/01
SUBJECT: Sentinel Events/Incidents	Page: 1 of 7
REFERENCE: JCAHO; CARF; COA; 45 C.F.R. §164.502(b)(1); 34 C.F.R. Part 99; HRS 334-5, HRS §350-1.1, HRS §350-1.2, Confidentiality of Records, CAMHD P&P 80.402, "Confidentiality, FAX Transmission."	APPROVED: <i>Signature on File</i> Chief

PURPOSE

To establish uniform guidelines for a reporting system for service provider agencies and Family Guidance Centers of the Child & Adolescent Mental Health Division that is designed to track and document significant client, family or staff events and follow-up of events. The system shall allow for clinical and administrative oversight as well as provision of data utilized towards preventive interventions.

DEFINITIONS

A ***sentinel event*** is an occurrence involving serious physical or psychological harm to anyone or the risk thereof, as defined under the categories of sentinel event codes and definitions. A sentinel event includes 1) any inappropriate sexual contact between youth, or credible allegation thereof; 2) any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof; 3) any physical or sexual mistreatment of a youth by staff, or credible allegation thereof; 4) any accidental injury to the youth or medical condition requiring attention by a medical professional or transfer to a medical facility for emergency treatment or admission; 5) medication errors and drug reactions; 6) any fire, spill of hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or 7) any incident of elopement by a youth.

An ***incident*** is defined as an occurrence that is a safety concern that is minor in nature and does not require major medical or staff intervention and is not identified as a reportable event as defined in the sentinel event codes and definitions. Incidents as defined here should be recorded and tracked internally, but do not need to be reported to CAMHD Sentinel Events Specialist.

Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.805
CAMHD Administration	Page	2 of 7

occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis, that no such improvement opportunities exist.

The product of the root cause analysis is an ***action plan*** that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

Individually Identifiable Health Information means information that is a subset of protected health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information means individually identifiable health information that is transmitted by electronic media or maintained in electronic form/medium. Protected health information excludes individually identifiable health information in: (1) Education record covered by the Family Educational Rights and Privacy Act (FERPA) as amended by 20 U.S.C. 1232g; (2) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (3) Employment records held by a covered entity in its role as employer. CAMHD client clinical records, and those of its contracted providers, are considered “educational records” that come under FERPA authority. However, for the purpose of reporting a sentinel event, individually identifiable health information will be exchanged following HIPAA guidelines for handling PHI.

POLICY

Incidents

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 80.805

CAMHD Administration

Page 3 of 7

Each agency shall track incidents internally in a manner allowing identification of trends and patterns in order to implement improvements.

Sentinel Events

1. Sentinel events shall be documented and reported to the CAMHD Performance Management Office's Sentinel Events Specialist, and to the Family Guidance Centers with which youths are registered. All events that occur during the period a client is receiving services must be reported, including events not witnessed directly by agency staff. Providers are required to track and analyze the occurrence of both sentinel events and incidents as part of their quality improvement program.
2. A safe and therapeutic environment is immediately established following any event in which the safety of youths, families, community members, or staff, is compromised.
3. The provider will determine:
 - a. Triggers that caused the event to occur;
 - b. Root causes of the sentinel event;
 - c. A detailed assessment and analysis of the sentinel event, and
 - d. A time-limited plan or strategy that allows the primary agency or party with oversight authority to adopt and implement a corrective course of action that reduces the probability of similar events reoccurring with any youth.

Minimum Necessary applies. When using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

PROCEDURE

Incidents

Provider's Responsibility:

Incidents shall be reported and tracked internally by each agency. The agencies shall analyze incidents to identify areas of need for changes in general operations, program, staffing, training, or supervision. Results of these analyses shall be reported in the agencies quarterly Quality Improvement Report to CAMHD.

CAMHD's Responsibility:

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.805
CAMHD Administration	Page	4 of 7

Performance Management Reviewers shall conduct desk reviews or on-site reviews of providers' system of tracking and analyses in full detail whenever special investigations, regular agency case-based reviews, or licensing reviews are conducted.

Sentinel Events

Provider's Responsibility:

1. Providers shall notify the CAMHD Sentinel Events Specialist, the client's legal guardian, and the Family Guidance Center Branch Chief or Care Coordinator with whom the client is affiliated, within 24 hours of the occurrence of the sentinel event, either by phone or fax. Any fax transmissions that contain protected health information about consumers shall follow protocol pursuant to CAMHD P&P 80.402, "Confidentiality, FAX Transmission."
2. All critical events involving serious injury or death, suicidal attempts, sexual misconduct, allegations of staff abuse or misconduct, shall be reported by telephone to CAMHD's Sentinel Event Specialist *within 2 hours* of event occurrence. In instances of child abuse or neglect, or suspected child abuse or neglect, CAMHD and/or its contracted providers are mandated to report the incident(s) to the Department of Human Services (DHS) or to the police department, pursuant to HRS §350-1.1. Penalties for non-reporting are codified under HRS §350-1.2.
3. Written preliminary reports to the above critical situations must be faxed to the CAMHD's Sentinel Event Specialist by 2 p.m. Monday through Friday. Such reports are to be followed by a full investigative report within 72 hours of the event occurrence.
4. Events must be reported using CAMHD's standard 72 Hour Sentinel Event Report form (see attachment) and must be received by the CAMHD Sentinel Events Specialist within 72 hours of the sentinel event by fax (733-9357). Reports must also be received by the Mental Health Care Coordinator within 72 hours of the sentinel event by fax at the appropriate Family Guidance Center fax number. The documentation shall include:
 - a. A written description of the event,
 - b. Youth's name, date of birth,
 - c. Immediate actions taken,
 - d. Review and identification of precipitating events,

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.805
CAMHD Administration	Page	5 of 7

- e. Analysis of actions on the part of staff that may have reduced the severity of the occurrence, and
 - f. Action that will be or have been taken in the attempt to prevent future similar occurrences.
5. The provider agency's Clinical Director shall review and provide comments to each 72 hour report to ensure legibility, accuracy, completeness, and clinical/administrative adequacy prior to its release to CAMHD.
6. Providers are expected to maintain a systematic log of their sentinel events on a manual or electronic database to generate reports to conduct their internal reviews and analyses. Aggregate analyses, findings and actions taken to reduce frequency of occurrences shall be a part of the agency's overall Quarterly Quality Improvement Report submitted to CAMHD. Further, comparisons shall be made of each ensuing quarter against previous quarters' findings.

CAMHD's Responsibility:

1. The Sentinel Events Specialist shall maintain a tracking log of all sentinel notifications and 72-hour reports to determine whether further information is necessary in instances where immediate action by the provider and CAMHD is warranted.
2. The CAMHD's Sentinel Events Specialist shall track the timeliness and adequacy of providers' 72-hour reports. The Specialist shall consult with an appropriate Performance Management Office or Clinical Services Office clinician as necessary.
3. The CAMHD's Sentinel Events Specialist reviews all sentinel reports and immediately notifies the Performance Management Supervisor of critical safety/risk management concerns. Situations of critical concern may require immediate on-site investigations conducted by the Performance Management Office clinical staff; or at the very least, immediate information, guidance, and requests of the agency are conducted in writing or by telephone.
4. If further investigation is deemed necessary a CAMHD team comprised of Performance Management, Clinical Services and/or FGC staff members shall conduct a thorough assessment of the event. A written report of the findings and recommendations will be prepared and sent to the agency through the Performance Management Supervisor, with copies distributed to all CAMHD sections including affected Family Guidance Centers. Clinical reviewers shall follow-through and monitor required documents and adequacy of corrective action from the agency.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.805
CAMHD Administration	Page	6 of 7

5. The CAMHD's Sentinel Events Specialist shall maintain an electronic database of all sentinels reported by providers or Family Guidance Centers. Various reports are aggregated from data fields sorted by provider with comparisons among all providers of like services on a quarterly basis. CAMHD's Safety and Risk Management Committee, and the Performance Improvement Steering Committee (PISC) shall review these reports. Additionally, such reports are also incorporated into CAMHD's quarterly report to Med-QUEST Division.
6. Full detailed reports are generated for Performance Management Reviewers in preparation for agencies' case-based reviews.

Collaborative Responsibility:

1. A formal Root Cause Analysis.
 - a. The investigation with subsequent detailed written Action Plan will be conducted for the following, most serious sentinel events and other serious sentinel events as determined by Chief, CAMHD, or CAMHD Safety and Risk Management Committee:
 - 1) Suicide,
 - 2) Homicide,
 - 3) Accidental death,
 - 4) Serious physical injury requiring hospitalization, and
 - 5) Rape.
 - b. A Root Cause Analysis and Action Plan shall be conducted within two (2) months of the most serious sentinel event.
 - c. The Root Cause Analysis and Action Plan shall be conducted by a team of CAMHD professional staff and others as deemed necessary and appropriate. This team shall be convened by CAMHD Performance Manager and Medical Director. Agencies will provide all information requested by the team and participate in the Root Cause Analysis, when appropriate. Members of the team shall include at the minimum:
 - 1) A licensed clinical mental health professional,
 - 2) A quality assurance specialist,
 - 3) An administrator, and
 - 4) Other representatives to assure all parties involved participate in the Root Cause Analysis and Action Plan.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.805
CAMHD Administration	Page 7 of 7

- d. A formal written report, including Root Cause Analysis and Action Plan will be prepared for review by the Chief of CAMHD and by CAMHD Safety and Risk Management Committee.
- e. Youth who are on waiting lists, who have had telephone contact with the system of care, or who are within six months following discharge shall be included in this policy.

ATTACHMENT(S)

- 1. 72-Hour Sentinel Event Report Form
- 2. Sentinel Event Code Definitions

Review Dates: ____/____/____; ____/____/____; ____/____/____; ____/____/____/

Chief's Initials: [_____] [_____] [_____] [_____]

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.813
CAMHD Administration	Effective Date: March 28, 2003 History: New
SUBJECT: Notice of Privacy Practice	Page: 1 of 10
REFERENCE: 45 C.F.R. §164.520, 164.504(a), 164.508(b)(5), 164.522(a)-(b), 164.530(i)(2)(ii); 34 C.F.R. Part 99 (FERPA); HRS §622-58 Retention of Medical Records	APPROVED: <i>Signature on File</i> Chief

PURPOSE

To define the requirements of, and the implementation of, the Child and Adolescent Mental Health Division's (CAMHD) Notice of Privacy Practice ("Notice").

DEFINITION

Authorizations – Point-in-time authorizations required for uses and disclosures of protected health information not otherwise permitted by this P&P or any other CAMHD requirements for the use or disclosure of protected health information (PHI).

Informed Consent to Release of Confidential Information –a consent form that must: (1) Identify the person who is authorized to disclose the protected health information; (2) Identify the client; (3) Describe the nature of and time span of the protected health information to be disclosed; (4) Identify to whom the protected health information is to be disclosed; (5) Describe the purpose of the disclosure; (6) State that the consent is subject to revocation; and (7) Include the date upon which the consent to disclose ends.

HHS –U.S. Department of Health and Human Services.

Individually identifiable health information – information that is a subset of protected health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - (a) That identifies the individual; or

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.813
CAMHD Administration	Page	2 of 10

- (b) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information –individually identifiable health information that is transmitted by electronic media or maintained in electronic form/medium. Protected health information excludes individually identifiable health information in: (1) Education records covered by the Family Educational Rights and Privacy Act (FERPA) as amended by 20 U.S.C. 1232g; (2) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (3) Employment records held by a covered entity in its role as employer.

Personally Identifiable Information –information found in educational records that includes, but is not limited to: 1) the student’s name; 2) the name of the student’s parent or other family member; 3) the address of the student or student’s family; 4) a personal identifier, such as the student’s social security number or student number; 5) a list of personal characteristics that would make the student’s identity easily traceable; or 6) other information that would make the student’s identity easily traceable.

Education Records –those records that are: 1) directly related to a student; and 2) maintained by an educational agency or institution or by a party acting for the agency or institution.

Parent –a parent of a student or consumer and includes a natural parent, or legal guardian.

Eligible Student - a student who has reached 18 years of age or is attending an institution of postsecondary education.

HIPAA Disclosure – the release, transfer, grant of access to, or divulging in any other manner of PHI to a person or entity outside of the entity that possesses the PHI.

FERPA Disclosure – to permit access to or the release, transfer, or other communication of personally identifiable information contained in education records to any party, by any means, including, but not limited to, oral, written, or electronic means.

POLICY

Through a single Notice, CAMHD will inform the parent or legal guardian of each consumer of their privacy rights under HIPAA and FERPA, and how their protected health information or personally identifiable information may be used. The Notice will separate and identify the privacy rights as it applies to the two federal statutes.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.813
CAMHD Administration	Page	3 of 10

CAMHD will post a copy of the Notice in a clear and prominent location at the Central Office and each Family Guidance Center (FGC), and provide the parent of each consumer with a copy of its Notice (1) upon first enrollment with the division; (2) to current participants in CAMHD services; and (3) provide the consumer with a revised Notice, whenever material revisions are necessary.

For FERPA compliance, and applicable only to consumers who fall exclusively under FERPA or HIPAA/FERPA jurisdiction, the Notice will inform the parent or eligible student that they have the right to:

1. Inspect and review the student's education records;
2. Seek amendment of the student's education records that the parent or eligible student believes to be inaccurate, misleading, or otherwise in violation of the student's privacy rights (see P&P 80.603.1, "Individual Right to File Complaints About Privacy Policies and Procedures or Compliance with Policies and Procedures");
3. Consent to disclosures of personally identifiable information (PII) contained in the student's education records, except to the extent that the Act authorize disclosure without consent;
4. File with the U.S. Department of Education a complaint concerning alleged failures by the educational agency or institution to comply with the requirements of the Act and this part (*see* P&P 80.603.1); and
5. Obtain the address of the Secretary of the U.S. Department of Education.

PROCEDURE

- A. Effective April 14, 2003, CAMHD will provide each individual with a Notice:
 1. Prior to or on the date of first service delivery;
 2. As soon as reasonable and practical after an emergency treatment situation;
 3. Automatically and contemporaneously, in an electronic format, if CAMHD delivers its first service to the individual electronically.
- B. CAMHD must provide notice:
 1. No later than the compliance date for CAMHD, to individuals then covered by CAMHD;
 2. Thereafter, at the time of enrollment, to individuals who are new enrollees;
 3. Within sixty (60) days of a material revision to the notice, to individuals then covered by CAMHD; and

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.813
CAMHD Administration	Page	4 of 10

4. No less frequently than once every three years, CAMHD must notify individuals then covered by the CAMHD of the availability of the notice and how to obtain the notice.
- C. CAMHD will ask the parent or legal guardian of the consumer to acknowledge in writing that he/she has received the Notice.
- D. CAMHD will post the Notice in a clear and prominent location within the Central Office's reception area and at each Family Guidance Center (FGC), so that parent or legal guardian seeking service from CAMHD will be able to read the Notice. CAMHD will also have the Notice available at the Central Office and FGC for parents or legal guardians who would like to take a copy with them.
- E. The Notice will include the following elements:
 1. The header statement, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."
 2. A description and at least one example of uses and disclosures related to treatment, payment and health care operations.
 3. Other uses or disclosures that CAMHD is permitted or required to make without the parent's authorization.
 4. A statement that other uses and disclosures will be made only with the parent's written authorization and that the parent may revoke such authorization.
 5. If applicable, a statement that CAMHD may contact the parent to provide appointment reminders, information about treatment alternatives or other health-related services, e.g., treatment team meetings, CSP meetings, etc.
 6. A statement and brief description of the parent's rights to:
 - (a) Request restrictions on certain uses and disclosures, accompanied by a statement that CAMHD is not required to agree to a requested restriction;
 - (b) Receive confidential communications;
 - (c) Inspect and copy protected health information;
 - (d) Amend protected health information;
 - (e) Receive an accounting of disclosures; and
 - (f) Obtain a paper copy of the Notice from CAMHD upon request, even if the parent has agreed to receive the Notice electronically.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.813
CAMHD Administration	Page	5 of 10

7. A statement that CAMHD:
 - (a) Is required by law to maintain the privacy of protected health information and to provide parents with the Notice;
 - (b) Is required to abide by the terms of the Notice currently in effect; and
 - (c) If applicable, reserves the right to change the terms of its Notice and to make provisions of the new Notice effective for all protected health information it maintains. CAMHD will also describe how it will provide parents with a revised Notice.
 8. A statement and brief description of the parent's right to complain, without fear of retaliation, to CAMHD and to the Secretary of Health and Human Services if he/she believes his/her child's privacy rights have been violated.
 9. The name, title and telephone number of a person or office to contact for further information.
 10. The effective date of the Notice.
 11. If applicable, a description of more limited uses and disclosures observed by CAMHD.
- F. Under a separate heading for FERPA, the Notice must include all of the following:

If your child's records are considered "educational records," CAMHD will only disclose information contained in your child's education records pursuant to FERPA requirements. Your child's FERPA notice is provided to you by the Department of Education and is hereby referenced in this Notice.

Note:

The following FERPA-related information is for reference purposes in CAMHD's notice and is only mentioned in this P&P as it pertains to procedure relating to FERPA issues. This information may, or may not, be incorporated in the Department of Education's notice. Aside from the abovementioned statement, these elements are not contained in the CAMHD notice.

1. The procedure for exercising the right to inspect and review education records.
2. Consent to release PII is not required when:
 - (a) The disclosure is to other school officials, including teachers, within the agency or institution, whom the agency or institution has determined to have legitimate educational interests;

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.813
CAMHD Administration	Page	6 of 10

- (b) The disclosure is to officials of another school, school system, or institution of postsecondary education where the student seeks or intends to enroll, where:
 - (i) A reasonable attempt to notify the parent or eligible student at the last known address of the parent or eligible student, unless (1) the disclosure is initiated by the parent or eligible student; or (2) the annual notification of the agency or institution includes a notice that the agency or institution forwards education records to other agencies or institutions that have requested the records and in which the student seeks or intends to enroll.
 - (ii) It gives the parent or eligible student, upon request, a copy of the record that was disclosed; and
 - (iii) It gives the parent or eligible student, upon request, an opportunity for a hearing.
- (c) An educational agency or institution may disclose an education record of a student in attendance to another educational agency or institution if (1) the student is enrolled in or receives services from the other agency or institution; and (2) the disclosure meets the requirements of paragraph (a) of this section.
- (d) The disclosure is to authorized representatives in connection with an audit or evaluation of Federal or State supported education programs, or for the enforcement of or compliance with Federal legal requirements which relate to those programs. These authorized representatives are:
 - (i) The Comptroller General of the United States;
 - (ii) The Attorney General of the United States;
 - (iii) The Secretary; or
 - (iv) State and local educational authorities.

The information collected must: (1) be protected in a manner that does not permit personal identification of individuals by anyone except the officials referred to in this section; and (2) be destroyed when no longer needed for the purposes listed in this section.

However, (1) and (2) of this section does not apply if: (1) the parent or eligible student has given written consent for the disclosure; or (2) the collection of personally identifiable information is specifically authorized by Federal law.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.813
CAMHD Administration	Page	7 of 10

- (e) The disclosure is in connection with financial aid for which the student has applied or which the student has received, if the information is necessary for such purposes as to:
 - (i) Determine eligibility for the aid;
 - (ii) Determine the amount of the aid;
 - (iii) Determine the conditions for the aid; or
 - (iv) Enforce the terms and conditions of the aid. As used in paragraph (e) of this section, “financial aid” means a payment of funds provided to an individual (or a payment in kind of tangible or intangible property to the individual) that is conditioned on the individual’s attendance at an educational agency or institution.
- (f) The disclosure is to State and local officials or authorities to whom this information is specifically:
 - (i) Allowed to be reported or disclosed pursuant to State statute adopted before November 19, 1974, if the allowed reporting or disclosure concerns the juvenile justice system and the system’s ability to effectively serve the student whose records are released; or
 - (ii) Allowed to be reported or disclosed pursuant to State statute adopted after November 19, 1974, if reporting or disclosure allowed by State statute concerns the juvenile justice system and the system’s ability to effectively serve, prior to adjudication, the student whose records are released, an educational agency or institution may disclose education records. The officials and authorities to whom the records are disclosed shall certify in writing to the educational agency or institution that the information will not be disclosed to any other party, except as provided under State law, without the prior written consent of the parent of the student.
- (g) Paragraph (f) of this section does not prevent a State from further limiting the number or type of State or local officials to whom disclosures may be made under that paragraph.
- (h) The disclosure is to organizations conducting studies for, or on behalf of, educational agencies or institutions to:
 - (i) Develop, validate, or administer predictive tests;

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.813
CAMHD Administration	Page	8 of 10

- (ii) Administer student aid programs; or
 - (iii) Improve instruction.
 - (i) The agency or institution may disclose information under paragraph (h) of this section only if: (1) The study is conducted in a manner that does not permit personal identification of parents and students by individuals other than representatives of the organization; and (2) The information is destroyed when no longer needed for the purposes for which the study was conducted.
 - (j) If the Office determines that a third party outside the educational agency or institution to whom information is disclosed under this paragraph (h) violates paragraph (i)(2) of this section, the educational agency or institution may not allow that third party access to personally identifiable information from education records for at least five years.
 - (k) For the purposes of paragraph (h) of this section, the term “organization” includes, but is not limited to, Federal, State and local agencies, and independent organizations.
 - (l) The disclosure is to accrediting organizations to carry out their accrediting functions.
 - (m) The disclosure is to parents of a dependant student, as defined in section 152 of the Internal Revenue Code of 1968.
 - (n) The disclosure is to comply with a judicial order or lawfully issued subpoena. See P&P 80.404 “Release of Clinical Information Pursuant to a Subpoena and Subpoena Duces Tecum.”
3. The procedure for requesting amendment of records, pursuant to P&P 80.603.1, when:
- (a) A parent or eligible student believes the education records relating to the student contain information that is inaccurate, misleading, or in violation of the student’s rights of privacy, he or she may ask the educational agency or institution to amend the record.
 - (b) The educational agency or institution shall decide whether to amend the record as requested within a reasonable time after the agency or institution receives the request.
 - (c) If the educational agency or institution decides not to amend the record as requested, it shall inform the parent or eligible student of its decision and of his or her right to a hearing.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number:	80.813
CAMHD Administration	Page	9 of 10

4. If the educational agency or institution has a policy of disclosing education records to other school officials --including teachers, within the agency or institution whom the agency or institution has determined to have legitimate educational interests-- a specification of criteria for determining who constitutes a school official and what constitutes a legitimate educational interest.
5. If there is a material change to CAMHD's privacy practices, CAMHD will promptly revise and distribute (within 60 days) its Notice to individuals currently participating, as described in sections A, C and D above. Changes to terms of the Notice will be implemented on or after the effective date of the Notice, except when otherwise required by law.
6. CAMHD will prominently post the Notice on its web site.
7. CAMHD may e-mail the Notice to an individual. If CAMHD knows that an e-mail transmission has failed, CAMHD will provide a paper copy of the Notice to the individual. In addition, upon request, CAMHD will provide a paper copy of the Notice to any individual who receives the Notice electronically.
8. CAMHD will retain copies of its Notices for six (6) years. CAMHD will also retain individuals' written acknowledgement of receipt of the Notice and documentation of good faith efforts to obtain such written acknowledgements for seven years. In the case of minors, written acknowledgement of the Notice shall be retained during the period of minority plus seven years after the minor reaches the age of majority.
9. CAMHD may issue a joint Notice, which:
 - (a) Describes the covered entities to which the Notice applies.
 - (b) Describes the service delivery sites to which the Notice applies.
 - (c) States that the covered entities (provider) participating in the organized health care arrangement will share protected health information with each other as necessary to carry out the treatment, payment or health care operations functions of the organized health care arrangement
10. CAMHD will provide the Notice to individuals as described in sections A, B and C above, and material revisions to the Notice as described F. Provision of the joint Notice to an individual by any one of the covered entities will satisfy the provision requirement for all other participating covered entities.

ATTACHMENT:

1. Notice of Privacy Practice

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	Number: 80.813
CAMHD Administration	Page 10 of 10

Review Dates: ____/____/____; ____/____/____; ____/____/____; ____/____/____/

Chief's Initials: [_____] [_____] [_____] [_____] [_____]